THE ROLE OF LAW IN THE TREATMENT DECISIONS OF DOCTORS

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The health system is complex. Regulating those who operate within it, however, is key to the effective promotion of the goals of the system. Regulating individuals can, in turn, be understood in terms of the regulation of their decisions. Julia Black's 'decentred regulation', with her notion of the 'ungovernable' individual, is a step in the right path towards understanding the regulation of decisions, but it does not go far enough. With a discussion of the intersection of law and ideas from behavioural economics and psychology, this article explores the regulation of the health system in terms of the embedded decision-making of medical practitioners. The analysis will be rounded out with an assessment of four categories of decisions — conscientious objection, defensive medicine, decisions (properly seen as errors) that lead to patient harm and the prescription of 'active placebos'.

I INTRODUCTION

Many doctors hold the lives of patients in their hands. The decisions they make, therefore, have a key role in the welfare of those in the practitioners' care. A range of legal frameworks can be assumed to impact on those treatment decisions, such as through the setting of standards and the provision of penalties; however, it is not clear how effective the laws are as a form of *regulation*. This is, in part, because most regulatory theories do not focus on how the individual engages with the rules that surround them, instead looking at the roles of institutions.[1] Of course, the law is not the only prism that may be used to judge behaviour. It is, nonetheless, a key one; it is also one that can acknowledge the role of other discourses in the lives of practitioners. The approach taken here, then, follows on from the notion that if we want to optimise behaviour, then we have to focus on the decisions that give rise

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1 Though some do consider aspects of the human condition in their analysis — for example, the perceived roles of norms and trust in the idea of 'polycentric regulation': Elinor Ostrom, 'Beyond Markets and States: Polycentric Governance of Complex Economic Systems' (2010) 100(3) *American Economic Review* 641, 660–1. Earlier iterations of the theory had a more institutional focus: see Vincent Ostrom, Charles M Tiebout and Robert Warren, 'The Organization of Government in Metropolitan Areas: A Theoretical Inquiry' (1961) 55(4) *American Political Science Review* 831. 'Polycentric regulation' has also been applied in the area of health, however, it has not focussed on the decisions of the regulated practitioners: see, eg, Belinda Bennett et al, 'Australia's National Registration and Accreditation Scheme for Health Practitioners: A National Approach to Polycentric Regulation?' (2018) 40(2) *Sydney Law Review* 159.

to behaviour. More specifically, if we want to govern those decisions, we need to consider the categories, and processes, that impact on those decisions.

One theoretical model that goes a long way to accommodating that complexity is that of 'ungovernability' in Julia Black's 'decentred regulation'.[2] This idea, while allowing a *greater* focus on the individual; the theory, is not nuanced enough to cover fine-grained, systemically embedded, actions of individual professionals.[3] The research here explores a deeper understanding of the regulated individuals themselves, including the relationships within which treatment decisions are made, through the use of ideas from behavioural economics[4] and decision-making theory[5] (the link between the latter two bodies of knowledge is unsurprising given the connections between behavioural economics and psychology).[6] The decisions of doctors make an ideal site of analysis as a result of the range of observable factors that go into the decisions, and the clear legal, and disciplinary,[7] constraints that frame them. The analysis works toward four points of discussion: the acknowledgement of *conscientious objection*; the operation of *defensive medicine* as a result of regulation; the characterisation of decisions behind medical errors; and the impact on *ungovernable* patients on the prescription of active placebos.

II AN EXPANDED VIEW OF THE DECISIONS OF 'UNGOVERNABLE' INDIVIDUALS

To consider the role of decision-making in healthcare requires an understanding of both the individuals and their decisions. The first aspect of this will be explored via an application of Black's theory. The second will explore the ideas from behavioural economics and psychology.

2 Julia Black, 'Critical Reflections on Regulation' (2002) 27 *Australian Journal of Legal Philosophy* 1, 8 ('Critical Reflections').

3 Other commentators have referred to Black's theory but have not applied the model to the Australian health system: see, eg, Fleur Beaupert et al, 'Regulating Healthcare Complaints: A Literature Review' (2014) 27(6) *International Journal of Health Care Quality Assurance* 505, 506; John Braithwaite, 'Leading from Behind with Plural Regulation' in Judith Healy and Paul Dugdale (eds), *Patient Safety First: Responsive Regulation in Healthcare* (Allen & Unwin, 2009) 24.

4 Of course, this is not the first work to do this: see, eg, Sophie Y Wang and Oliver Groene, 'The Effectiveness of Behavioral Economics-Informed Interventions on Physician Behavioral Change: A Systematic Literature Review' (2020) 15(6) *PLoS ONE* e0234149:1–20.

5 The significant research in the area will be discussed below. It has been noted that the 'role of cognitive biases and heuristics in medical decision making is of growing interest': J S Blumenthal-Barby and Heather Krieger, 'Cognitive Biases and Heuristics in Medical Decision Making: A Critical Review Using a Systematic Search Strategy' (2015) 35(4) *Medical Decision Making* 539, 545. However, this is the first to consider from a legal perspective.

6 See generally Christine Jolls, Cass R Sunstein and Richard Thaler, 'A Behavioral Approach to Law and Economics' (1998) 50(5) *Stanford Law Review* 1471.

7 With respect to the body of expert medical knowledge that doctors rely on.

A *The 'Ungovernable' Individual*

'Ungovernability', for Black, relates to the behaviour, attitudes, and autonomy of the regulated.[8] Black's work, drawing on Foucauldian understandings,[9] accommodates the view that regulators, understood broadly, act 'through countless, often competing, local tactics of education, persuasion, inducement, management, incitement, motivation and encouragement'.[10] To be clear, the components do not, in fact, suggest that doctors are ungovernable. Instead, the components merely suggest that there are great challenges associated with getting them to accept direct instructions that are contrary to the norms of behaviour in this area — with norms being seen as a fundamentally important part of the 'regulatory conversations' that take place in the processes of regulation.[11] Expressed differently, key to this aspect are the capacity of actors in a system to regulate their own behaviour;[12] their capacity to 'develop or act in their own way in the absence of intervention'[13] and the extent to which they are 'insusceptible to external regulation'.[14]

Black's understanding also engages with that 'external regulation' — the formal processes that impact on decisions of individuals. That is considered in terms of its 'complexity, fragmentation, interdependencies … and the rejection of a clear distinction between public and private'.[15] The *fragmented* legal frameworks aimed at doctors' behaviour are discussed below. As another example, a substantial aspect of the *interdependencies* of regulation and the *lack of distinction between the public and the private* in the health system arises from its funding. Organisations with a financial role include the state governments, the federal government, health insurance companies and, in some cases, charitable organisations. Expressed differently, there are a number of 'over- and under-lapping relationships … involving to a varying extent government departments, politicians, regulatory bodies, *target populations*, firms, shareholders and the wider public'.[16] Each

8 Black, 'Critical Reflections' (n 2) 6–7.

9 Ibid 3 n 4.

10 Peter Miller and Nikolas Rose, *Governing the Present: Administering Economic, Social and Personal Life* (Polity Press, 2008) 55.

11 Julia Black, 'Regulatory Conversations' (2002) 29(1) *Journal of Law and Society* 163, 163 ('Regulatory Conversations').

12 This aspect is, therefore, close to Foucauldian understandings of the manner in which the governed operate in today's society: see generally Michel Foucault, 'Governmentality' in Graham Burchell, Colin Gordon and Peter Miller (eds), *The Foucault Effect: Studies in Governmentality* (Harvester Wheatsheaf, 1991) 87.

13 Black, 'Critical Reflections' (n 2) 6.

14 Ibid 7.

15 Ibid 4.

16 Martin Lodge, 'Accountability and Transparency in Regulation: Critiques, Doctrines and Instruments' in Jacint Jordana and David Levi-Faur (eds), *The Politics of Regulation: Institutions and Regulatory Reforms for the Age of Governance* (Edward Elgar, 2004) 124, 125. As an example of public input into the health system, the Victorian voluntary assisted dying legislation was not the direct result of either the government or the Australian Medical Association pushing

funder has its own expectations and requirements regarding the institution's performance — with the institutions, in turn, potentially impacting on the behaviour of individual practitioners.

For Black, fragmentation includes the 'fragmentation … of knowledge';[17] or more fully, fragmentation means that 'no single actor has all the knowledge required to solve complex, diverse and dynamic problems'.[18] This, of course, relates to the complexity aspect of the model — with the different categories of institutional pressure (including, with respect to the funding arrangements, accountants and policy makers) being delimited by their own disciplinary knowledge.[19] In the health context, however, there is the further issue of a fragmented sense of the *public good*.[20] Different conceptions include an *efficient* health system (which could relate either to the number of patients seen, treated, or cured for a given dollar figure), a system that shifted costs away from the public purse, a system that optimised (or maximised) the health of those who engaged with it, or a system that optimised (or maximised) the health of the whole population. Each sense of the public good prioritises different practices of health institutions and practitioners. Finally, even when only the one on one interaction between the practitioner and their patient is considered, there may be fragmentation in the understandings of the outcome — in that both parties may not agree on what constitutes the patient's best interests, or even on what constitutes *good health*.[21]

It is this tension between self-responsibility (or ungovernability) and the external pressure applied by a range of institutions and processes that is at the heart of decentred regulation. This arises, in part, because this form of 'regulation seeks to

for reform in the area. The Bill came as a result of the recommendations in the *Ministerial Advisory Panel on Voluntary Assisted Dying*: Department of Health and Human Services (Vic), *Ministerial Advisory Panel on Voluntary Assisted Dying* (Final Report, July 2017) 22–32. That Panel was formed after the Report of the Legislative Council Legal and Social Issues Committee: Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report, June 2016). The Committee highlighted the role of the Grattan Institute's 2014 Report, *Dying Well*, and the opinion polls that suggested public support for reform: at 11–12, citing Hal Swerissen and Stephen Duckett, Grattan Institute, *Dying Well* (Report, September 2014) 5.

17 Julia Black, 'Decentring Regulation: Understanding the Role of Regulation and Self-Regulation in a "Post-Regulatory" World' (2001) 54(1) *Current Legal Problems* 103, 107.

18 Black, 'Critical Reflections' (n 2) 5.

19 A practitioner's training, and their professional association, is defined by their discipline; the actions of the insurance companies are delimited by the economics and accounting disciplines; and the National Boards, as creations of the National Law, are significantly constrained by the legal discipline: see below Part III. The Australian Health Practitioner Regulation Agency ('AHPRA') system will also be discussed below.

20 For a discussion of competing senses of the public good in a related area, see Chris Dent and Yvonne Haigh, 'Oligopolist Speech and the Public Interest in Pharmaceutical Patent Law Reform' (2017) 33(1) *Canadian Journal of Law and Society* 1.

21 A patient who smokes, for example, may not think that quitting is in their interests; or as a more extreme example, with the introduction of assisted dying legislation — such as the *Voluntary Assisted Dying Act 2017* (Vic) — a patient may want to die, but the practitioner may disagree (though this is only relevant where the circumstances of the patient meet the requirements of the Act).

harness individuals in civil society as part of the regulatory project'.[22] The acknowledgement of the tension, then, encourages the problematisation of the regulated actors — with a particular focus on their internalised norms of behaviour. As has been recognised by Black, the meaning of each norm is 'open to continual reinterpretation, depending on the actor's preoccupations and goals, the context of action, and who else is involved in the encounter'.[23] The further, key, aspect about norms is that there is a greater degree of voluntariness to compliance than there is to a sanction-backed command. This voluntariness means choice, and any choice to act, or not, is the result of a range of factors internal to the individual.[24]

B *'Motivators' and Decision-Making Theory*

Individual decisions, however, are not well catered for in the regulatory literature. It is on this basis that recourse is made here to ideas from behavioural economics and psychology. That is, one way of considering the *choice* of practitioners is to look at the *motivators* that may underlie a decision. These will be expanded on below; however, there is value in introducing them briefly here. Other applications of these to law[25] have adopted three sets of motivators — 'internal', 'external' and 'reputational'[26] — with each of the three containing two more specific motivators. The motivators impact on individuals differently, which accords with the '[v]ariety in controllees' noted by Scott.[27]

A motivator, for example, is considered to be *internal* if it relates to how an individual sees themselves as an individual. Such a motivator relates to how the person thinks they should act in relation to what they see as the *right* thing to do.[28] There are two subsidiary motivators here: (1) to do particular things because they

22 Iain Ramsay, 'Consumer Law, Regulatory Capitalism and the "New Learning" in Regulation' (2006) 28(1) *Sydney Law Review* 9, 13.

23 Black, 'Regulatory Conversations' (n 11) 176, citing Brian Z Tamanaha, *Realistic Socio-Legal Theory: Pragmatism and a Social Theory of Law* (Oxford University Press, 1997) 144.

24 For a different take on the issue, that is, a discussion of the interplay between an individual's emotional responses and regulation, see Bettina Lange, 'The Emotional Dimension in Legal Regulation' (2002) 29(1) *Journal of Law and Society* 197.

25 See, eg, Chris Dent, 'Decisions around Innovation and the Motivators that Contribute to Them: Patents, Copyright, Trade Marks and Know-How' (2016) 6(4) *Queen Mary Journal of Intellectual Property* 435.

26 Ibid 436. This categorisation accords with the understanding, in the psychological literature, that 'individuals have a utility function with three main components: they value extrinsic rewards, enjoy doing an activity and care about their image': Uri Gneezy, Stephan Meier and Pedro Rey-Biel, 'When and Why Incentives (Don't) Work to Modify Behaviour' (2011) 25(4) *Journal of Economic Perspectives* 191, 192, discussing Roland Bénabou and Jean Tirole, 'Incentives and Prosocial Behavior' (2006) 96(5) American Economic Review 1652.

27 Colin Scott, 'Regulation in the Age of Governance: The Rise of the Post-Regulatory State' in Jacint Jordana and David Levi-Faur (eds), *The Politics of Regulation: Institutions and Regulatory Reforms for the Age of Governance* (Edward Elgar, 2004) 145, 165–6.

28 As an example, 'conscientious objection' is one form of proper conduct that is relevant to certain medical practices. The form, however, is not without its critics. As one part of an ongoing debate, see Christopher Cowley, 'A Defence of Conscientious Objection in Medicine: A Reply to Schuklenk and Savulescu' (2016) 30(5) *Bioethics* 358.

reflect who they are as a person (*proper conduct for the self*);[29] and (2) *proper conduct for others*, where the individual focuses on the benefit that others may receive from a given course of action.[30] It has to be highlighted that *proper conduct* brings in specific frameworks that may impact on decisions. An individual's ethics, or their religious beliefs, have the potential to guide behaviour. Whether a particular position is adopted because an individual sees themselves as a *moral person*, or because they think that acting in accordance with that morality is good for society, it is the role of morality in the person's constitution that is prescriptive.[31] This will be discussed further below in the context of *conscientious objection*.

The second set of motivators comprises those that are external to the individual in that these motivators are explicitly offered, or threatened, by parties other than the individual herself. There are both positive and negative forms of these motivators — the former involving inducements from someone else and the latter potential penalties (including less formal sanctions, such as shunning or avoidance). The final category of motivators, the *reputational* ones, relate to the role particular actions have in altering how other people react to the person concerned. The first of these relates to an interest in establishing a separation from others — such as the creation of a piece of art as an embodiment of the creator's unique self or experience. The second relates to doing something in order to gain the esteem of others — a positive acknowledgment from another individual.

While *motivators* are more fine-grained than concepts like *ungovernability*, they still do not provide a complete picture of how individuals decide when faced with a situation that is framed by law. This means that one final body of knowledge may now be introduced — that of the psychology of decision-making. Two decision-making theories that are of particular value here relate to 'bounded rationality'[32] and *naturalistic decision making*. Herbert Simon, an economist and psychologist, is a key thinker in the area. In one of Simon's first explorations of the former theory, he argued for an 'approximate rationality' exercised by a 'choosing organism of limited knowledge and ability'.[33] Bounded rationality recognises that decisions 'cannot wait until everything relevant is known. The [decision-maker]

29 Of course, there is a strong Foucauldian flavour to the concept of 'proper conduct'. Aspects of Foucault's work emphasise the notion of the 'conduct of conduct': Michel Foucault, *Power*, ed James D Faubion, tr Robert Hurley et al (Penguin Press, 2001) vol 3, 341.

30 Behavioural economists refer to the latter as 'prosocial behaviour': see, eg, Roland Bénabou and Jean Tirole, 'Incentives and Prosocial Behaviour' (2006) 96(5) *American Economic Review* 1652.

31 If they act morally because they want to be seen as a moral person, then that becomes a reputational motivator.

32 See generally Jolls, Sunstein and Thaler (n 6) 1477–8.

33 Herbert A Simon, 'A Behavioral Model of Rational Choice' (1955) 69(1) *Quarterly Journal of Economics* 99, 114. For Etzioni, '[d]ecision-makers have neither the assets nor the time to collect the information required for rational choice': Amitai Etzioni, 'Mixed-Scanning: A "Third" Approach to Decision-Making' (1967) 27(5) *Public Administration Review* 385, 386.

makes a decision which he or she hopes will be satisfactory and will suffice to meet the organisation's needs at the moment'.[34]

This desire to do 'good enough' in the making of a decision is referred to as 'satisficing' behaviour.[35] Further, 'bounded rationality assumes that actors are goal-oriented' and 'that behavior is determined by the mix of incentives facing the decision maker'.[36] This articulation suggests links between this theory and the idea that motivators contribute to decisions.

'Naturalistic decision making theory'[37] has been defined as an examination of 'how experienced people, working … in dynamic, uncertain and often fast paced environments, identify and assess their situation, make decisions and take actions whose consequences are meaningful to them' and others.[38] It has been, more specifically, summarised as an analysis of 'how people use experience to make decisions in naturalistic environments (eg under time pressure, shifting conditions, unclear goals, degraded information and within team interactions). A common theme … is the role of expertise in decision-making'.[39] Much of the work is based on the recognition-primed decision model,[40] which 'describes how decision makers can rely on their experience to recognize situations and identify viable courses of action without comparing the relative benefits or liabilities of multiple courses of action'.[41]

That is, unlike earlier models of decision-making, there is an acknowledgement that in many situations, decisions are very quick. This, in turn, can be seen to be a recognition of the fact that an 'important attribute of expert decision makers is that they seek a course of action that is workable, but not necessarily the best or optimal

34 David Corbett, *Australian Public Sector Management* (Allen & Unwin, 2nd ed, 1996) 62.

35 Bryan D Jones, *Politics and the Architecture of Choice: Bounded Rationality and Governance* (University of Chicago Press, 2001) 61.

36 Bryan D Jones, 'Bounded Rationality' (1999) 2 *Annual Review of Political Science* 297, 299.

37 'Naturalistic decision making' has been described as a 'label for a loose grouping of nonstandard models of individual decision making': Terry Connolly and Ken Koput, 'Naturalistic Decision Making and the New Organizational Context' in Zur Shapira (ed), *Organizational Decision Making* (Cambridge University Press, 1997) 285, 285.

38 Caroline E Zsambok, 'Naturalistic Decision Making: Where Are We Now?' in Caroline E Zsambok and Gary Klein (eds), *Naturalistic Decision Making* (Psychology Press, 2014) 3, 5.

39 Taryn Elliott, 'Expert Decision-Making in Naturalistic Environments: A Summary of Research' (Research Paper, Defence Science and Technology Organisation, Department of Defence (Cth), March 2005) 8.

40 This is 'the model most closely associated with the [naturalistic decision-making] perspective': Rebecca Pliske and Gary Klein, 'The Naturalistic Decision-Making Perspective' in Sandra L Schneider and James Shanteau (eds), *Emerging Perspectives on Judgment and Decision Research* (Cambridge University Press, 2003) 559, 563.

41 George L Kaempf et al, 'Decision Making in Complex Naval Command-and-Control Environments' (1996) 38(2) *Human Factors* 220, 220.

decision';[42] an assessment that follows on from the 'bounded rationality' theory expounded by Simon. More specifically, one study has shown that decision-makers try to match 'features' of the situation before them with past experience, in order to produce a course of action.[43] That is, decision-makers build on their past experiences and follow a course of action in keeping with previous successes.

An alternative way of understanding these *quick* decisions is to see them as being, to an extent, 'automatized'.[44] Simon talks of this aspect in terms of 'habitual rationality'[45] and 'adaptive behavior'.[46] For him, there is value in this, as habits 'may not only serve their purposes effectively, but also conserve scarce and costly decision-making time and attention'.[47]

Vanberg expresses it more fully:

> [A]n actor's choice-behaviour is based on a repertoire of behavioural patterns, routines or programmes. The repertoire reflects, at any point in time, the actor's past experience, and it is, through trial and error, continuously adjusted as new experiences are undergone. Routines that are found to 'work well' tend to be retained, while experiences of failure encourage search for better programmes.[48]

This means that individuals can resort to shortcuts to assist their decisions.

This leads into the final aspect of decision-making to be considered — that of the unconscious aspects of decisions. Specifically, biases and heuristics may be used, unknowingly, in the process of finalising decisions, with '[u]nconscious processes exert[ing] multiple influences over people's preferences, choices, and behaviours, often in conflict with conscious intentions and outside of awareness'.[49] Touching

42 Jennifer K Phillips, Gary Klein and Winston R Sieck, 'Expertise in Judgment and Decision Making: A Case for Training Intuitive Decision Skills' in Derek J Koehler and Nigel Harvey (eds), *Blackwell Handbook of Judgment and Decision Making* (Blackwell Publishing, 2004) 297, 305.

43 Kaempf et al (n 41) 227. See also Ralph Hertwig, 'Decisions from Experience' in Gideon Keren and George Wu (eds), *The Wiley Blackwell Handbook of Judgment and Decision Making* (Wiley Blackwell, 2015) vol 1, 239.

44 Reinhard Selten, 'What is Bounded Rationality?' (SFB Discussion Paper No B–454, Dahlem Conference, May 1999) 4.

45 Herbert A Simon, *Administrative Behavior: A Study of Decision-Making Processes in Administrative Organizations* (Free Press, 4th ed, 1997) 89 ('*Administrative Behavior*').

46 Herbert A Simon, Models of Man: Social and Rational (John Wiley & Sons, 1957) 261.

47 Simon (n 45) 89.

48 Viktor Vanberg, 'Rational Choice, Rule-Following and Institutions: An Evolutionary Perspective' in Uskali Mäki, Bo Gustafsson and Christian Knudsen (eds), *Rationality, Institutions and Economic Methodology* (Routledge, 1993) 171, 180.

49 Emily Balcetis and Yael Granot, 'Under the Influence and Unaware: Unconscious Processing during Encoding, Retrieval and Weighting in Judgment' in Gideon Keren and George Wu (eds), *The Wiley Blackwell Handbook of Judgment and Decision Making* (Wiley Blackwell, 2015) vol 1, 333, 350, citing Larry L Jacoby, D Stephen Lindsay and Jeffery P Toth, 'Unconscious Influences Revealed: Attention, Awareness and Control' (1992) 47(6) *American Psychologist* 802.

on heuristics first, it has been said that 'judgment under [conditions of] uncertainty is often based on a limited number of simplifying heuristics rather than more formal and extensive algorithmic processing'.[50] Heuristics, then, can be seen as *rules-of-thumb* that contribute to 'fast and frugal' decisions.[51] They save mental space, and so they save time — they can work on the basis of memory,[52] they can operate on the basis of 'affect'[53] or in a range of other circumstances.[54] They are consistently used by people because they 'typically yield accurate judgments but can give rise to systematic error'.[55] At the very least, the engagement with decision-making theory, and motivators, problematises assumptions that may be made about the role of law in constraining the decisions of doctors.[56]

III LEGAL FRAMEWORKS FOR DECISIONS OF DOCTORS AROUND THEIR PATIENTS

In order to assess the potential impact of the law on the decisions of doctors, there needs to be a discussion of the relevant legal frameworks. That is not to say that law is the only limit on their behaviour — morality has already been alluded to, and the law gives legal effect to professional ethics — but it is a set of processes that accommodates the other pressures that impact on behaviours. The dominant legal framework for the regulation of treatment decisions, and other decisions made during consultations, is the substantially uniform *Health Practitioner Regulation National Law 2009* of each state and territory.[57] Other laws, including

50 Thomas Gilovich, Dale Griffin and Daniel Kahneman, 'Preface' in Thomas Gilovich, Dale Griffin and Daniel Kahneman (eds), *Heuristics and Biases: The Psychology of Intuitive Judgment* (Cambridge University Press, 2002) xv.

51 Gerd Gigerenzer, 'Fast and Frugal Heuristics: The Tools of Bounded Rationality' in Derek J Koehler and Nigel Harvey (eds), *Blackwell Handbook of Judgment and Decision Making* (Blackwell Publishing, 2004) 62, 63.

52 See, eg, Michael RP Dougherty, Scott D Gronlund and Charles F Gettys, 'Memory as a Fundamental Heuristic for Decision Making' in Sandra L Schneider and James Shanteau (eds), *Emerging Perspectives on Judgment and Decision Research* (Cambridge University Press, 2003) 125.

53 With 'affect', for the purposes of the research, being defined as the 'specific quality of "goodness" or "badness" (1) experienced as a feeling state (with or without consciousness) and (2) demarcating a positive or negative quality of a stimulus': Paul Slovic et al, 'The Affect Heuristic' in Thomas Gilovich, Dale Griffin and Daniel Kahneman (eds), *Heuristics and Biases: The Psychology of Intuitive Judgment* (Cambridge University Press, 2002) 397, 397.

54 See generally Gilovich, Griffin and Kahneman (n 50).

55 Ibid xv.

56 For a discussion of medical decisions more generally, see Gretchen B Chapman, 'The Psychology of Medical Decision Making' in Derek J Koehler and Nigel Harvey (eds), *Blackwell Handbook of Judgment and Decision Making* (Blackwell Publishing, 2004) 585; Anne M Stiggelbout, Marieke de Vries and Laura Scherer, 'Medical Decision Making' in Gideon Keren and George Wu (eds), *The Wiley Blackwell Handbook of Judgment and Decision Making* (Wiley Blackwell, 2015) vol 2, 775.

57 See, eg, *Health Practitioner Regulation National Law Act 2009* (Qld) sch ('*National Law*'). How the different jurisdictions deal with complaints is one point of difference. Queensland has, for example, incorporated complaints to the Health Ombudsman into its regulatory processes under the *Health Ombudsman Act 2013* (Qld). For a discussion of the complaints processes in terms of

the criminal law, may also be seen to limit the decisions of practitioners — though the extent to which they are present in the minds of practitioners is not clear.

A *The National Law*

The *National Law* is, more specifically, a framework for the *registration* of health practitioners.[58] As such, the *National Law* sets out the requirements for registration,[59] for the maintenance of registration of practitioners, and for its suspension or cancellation. The requirements include, for example, the necessary educational qualifications for registration.[60] There are also references to other obligations, such as the need to maintain '[p]rofessional indemnity insurance.[61] Unsurprisingly, a registration system needs an entity that oversees the registers. The Australian Health Practitioner Regulation Agency ('AHPRA') is the overarching regulator; the registers themselves are controlled by the 'National Boards'.[62] For doctors, the relevant board is the Medical Board of Australia ('MBA'). The National Boards also have a role in disciplining practitioners — through processes such as mandatory or voluntary notifications[63] — with adverse outcomes arising from disciplinary proceedings being recorded on the register.[64]

With respect to regulating the decisions of doctors, the MBA also 'develop[s] or approve[s] standards, codes and guidelines for the health profession'.[65] The codes and guidelines detail standards of behaviour which practitioners are required to meet. Importantly, these codes have significant legal effect.[66] For medical practitioners, the relevant code is the MBA's *Code of Conduct*.[67] A breach of this code may result in sanctions being applied, on the basis that the 'practitioner's

polycentric regulation, see Terry Carney et al, 'Health Complaints and Practitioner Regulation: Justice, Protection or Prevention?' (2017) 26(1) *Griffith Law Review* 65.

58 For a discussion of the effectiveness of the National Law as a piece of country-wide regulation, see Jenni Millbank, 'Health Practitioner Regulation: Has the National Law Produced National Outcomes in Serious Disciplinary Matters?' (2019) 47(4) *Federal Law Review* 631.

59 Unsurprisingly, then, the National Law sets out provisions around 'accredited programs of study' as the basis for registration: *National Law* (n 57) s 35(1)(d).

60 Ibid s 53. This provision is for 'general registration'; the requirements for 'specialist': at s 58; and 'student' registration are contained in separate provisions: at s 89.

61 Ibid s 129. The need for insurance is also included in the Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (at October 2020) cl 10.6 ('*Code of Conduct*').

62 *National Law* (n 57) ss 35(1)(a), (m).

63 Ibid pt 8 divs 2–3.

64 Ibid s 225.

65 Ibid s 35(1)(c).

66 Strictly speaking, 'in disciplinary proceedings against a medical practitioner, the question is not whether the impugned conduct is in "breach" of the Conduct Code. It is whether the conduct, as found, is behaviour on the part of a practitioner that constitutes unsatisfactory professional performance, unprofessional conduct or professional misconduct': *Panegyres v Medical Board of Australia* [2020] WASCA 58, [18] (Buss P and Murphy JA).

67 *Code of Conduct* (n 61).

professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner's professional peers'.[68]

Specific provisions contained in the *Code of Conduct*, such as the requirement for consent, will be returned to below. What is important at this point, however, is that there is a legal framework that sets clear standards of behaviour for doctors — when it comes to their engagements with their patients. These standards are the product of their peers, breaches of these standards have consequences for those who transgress, and there are mechanisms in place for reporting such breaches. As a final introductory point, where a National Board imposes a condition on a practitioner's registration, or suspends their registration, as a result of a notification, then this information is included in the practitioner's entry on the 'publicly accessible'[69] register of practitioners.[70]

B *Other Relevant Legal Frameworks*

There are three further legal frameworks that can impact on doctors' decisions around their patients. One of them, the law of negligence, is no stranger to the health system.[71] The other two, criminal law and contractual obligations, may have fewer immediate connections with the daily work of doctors, however, they may be seen to be in the background — as a limited form of constraint on their decisions.[72]

Negligence law, of course, does not only apply to healthcare practitioners. Given the potential for very large compensation payouts, however, the doctrine is of particular relevance to the professions. To begin, a practitioner may be liable for any harm caused to a patient where the practitioner's treatment decision was

68 *National Law* (n 57) s 144(1)(a). The New South Wales ('NSW') provision reads: the 'following complaints may be made about a registered health practitioner … A complaint the practitioner has been guilty of unsatisfactory professional conduct or professional misconduct': *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) s 144(b).

69 *National Law* (n 57) s 35(1)(l).

70 Ibid s 225.

71 Evidenced by the fact that the 'medical negligence' was specified in the Terms of Reference that gave rise to the Ipp Report: David Andrew Ipp et al, *Review of the Law of Negligence* (Final Report, September 2002) x. That report, in turn, gave rise to the substantially uniform civil liability legislation in each state and territory across Australia: see, eg, *Civil Liability Act 2002* (NSW).

72 It is also possible for the Coroner's Court to pass judgment on medical practitioners: see, eg, the comments made against Dr Penaneuva in Magistrate Harriet Grahame, *Inquest into the Death of Michaela Perrin* (State Coroner's Court of New South Wales, 27 February 2018). In this case, the coroner recommended the matter be referred to the Health Complaints Commission: at [104]. However, the coroner did not, nor does not, assess the decisions of practitioners against the requirements of a specific legal framework separate to the frameworks discussed here.

negligent.[73] Across Australia, there are specific provisions with respect to the standard of care owed by practitioners:[74]

> (1) An act or omission of a health professional is not a negligent act or omission if it is in accordance with a practice that, at the time of the act or omission, is widely accepted by the health professional's peers as competent professional practice.
> …
> (3) Subsection (1) applies even if another practice that is widely accepted by the health professional's peers as competent professional practice differs from or conflicts with the practice in accordance with which the health professional acted or omitted to do something.[75]

As such, treatment decisions of practitioners are judged against those of their peers; therefore, implicitly, practitioners should have such practices in mind when considering potential treatments.[76]

Of course, criminal law also applies to all members of society; however, given the physical nature of some aspects of patient care, there is a greater potential for an offence to occur than there is for many other professions. Practitioners have been accused of sexual assault of patients,[77] others have been jailed for assault,[78] and, more controversially, practitioners have been convicted of manslaughter as a result of bad treatment decisions.[79] Further, the criminal law has been used to dissuade

73 The '[g]eneral principles' for liability are set out in, for example, *Civil Liability Act 2002* (Tas) s 11.

74 Health practitioners, for the purpose of this provision, are defined as 'health professional[s]' regulated by the National Law and 'any other person who practises a discipline or profession in the health area that involves the application of a body of learning': *Civil Liability Act 2002* (WA) s 5PA.

75 *Civil Liability Act 2002* (WA) s 5PB. To take another example, a substantially similar provision is found in *Civil Liability Act 2003* (Qld) s 22. For a discussion of the defence, see Catherine Mah, 'A Critical Evaluation of the Professional Practice Defence in the Civil Liability Acts' (2014) 37(2) *University of Western Australia Law Review* 74, cited in *South Western Sydney Local Health District v Gould* (2018) 97 NSWLR 513, 541 [128] (Leeming JA). The preceding case law adopted a similar position: a 'doctor must act in accordance with *a* responsible and competent body of relevant professional opinion': *Re F* [1990] 2 AC 1, 78 (Lord Goff) (emphasis added), citing *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

76 Negligence will be returned to in the context of 'defensive medicine'.

77 A recent study looks at the number of AHPRA registered healthcare practitioners who have received a formal notification with respect to sexual misconduct. Over the period studied, there were 1126 notifications for either sexual harassment or sexual assault: Marie M Bismarck et al, 'Sexual Misconduct by Health Professionals in Australia, 2011–2016: A Retrospective Analysis of Notifications to Health Regulators' (2020) 213(5) *Medical Journal of Australia* 218, 221. The rate of notifications for general practitioners was the second highest of the professions (after psychiatrists) — at a rate of 21.9 per 10,000 practitioner years: at 222. The analysis does not (and could not) report how many of these progressed to criminal prosecutions. Another study shows that, of the doctors who were proved, under the *National Law*, to have engaged in sexual misconduct, 48.4% were deregistered and 30.6% had their registration suspended: Millbank (n 58) 641.

78 See, eg, *Reeves v The Queen* (2013) 304 ALR 251.

79 One high profile example of this is that of Dr Bawa-Garba, who was convicted in 2015 of manslaughter (by gross negligence) over the death of a six-year-old boy. A nurse was also

doctors from performing abortions[80] and euthanasia.[81] More generally, criminal behaviour involving harm to a patient may either be intentional or the result of negligence.[82] For both, the potential for sanctions, that include imprisonment, is seen as a curb on problematic behaviour on the part of practitioners[83] — though it would be difficult to ascertain the extent to which the threat of criminal law impacts on such behaviour.[84]

The final set of legal obligations arise from the contracts that exchange the labour of the practitioner for remuneration. Of course, these obligations do not arise where the practitioner is a sole practitioner;[85] however, a significant number of practitioners are either employed by an organisation, owe obligations as a contractor, or owe obligations under a partnership agreement.[86] All three of these relationships are delimited, to a large extent, by contractual clauses. The purpose of any contract is to modify behaviour (even if the action is only to give up, or to

convicted. Bawa-Garba's appeal was rejected in 2016: *Bawa-Garba v The Queen* [2016] EWCA Crim 1841. A very small number of practitioners have been convicted, in Australia, for errors. One case is that of Dr Arthur Gow, who prescribed morphine tartrate instead of morphine sulphate. This led to the patient overdosing. Gow was convicted of manslaughter and also was subject to sanctions under the *Medical Practice Act 1992* (NSW): *Health Care Complaints Commission v Gow* [2008] NSWMT 2. See also David J Carter, 'Correcting the Record: Australian Prosecutions for Manslaughter in the Medical Context' (2015) 22(3) *Journal of Law and Medicine* 588.

80 It was only relatively recently that some state jurisdictions, for example, Queensland and NSW, removed the abortion provisions from their criminal legislation. Western Australia ('WA') retains a provision criminalising abortion, save for where the 'abortion is performed by a medical practitioner in good faith and with reasonable care and skill; and the performance of the abortion is justified under section 334 of the *Health (Miscellaneous Provisions) Act 1911*': *Criminal Code Act Compilation Act 1913* (WA) s 199(1).

81 For example, '[p]rocuring, counselling or aiding another to kill themselves remains a serious offence under the WA Criminal Code … In addition, consent by a person to the causing of their own death, does not affect the criminal responsibility of the killer': Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice* (Report No 1, 23 August 2018) 139 [4.113] (citations omitted). Of course, this assessment was prior to the passing of the *Voluntary Assisted Dying Act 2019* (WA).

82 For example, a 'person who by negligently doing or omitting to do an act causes serious injury to another person is guilty of an indictable offence': *Crimes Act 1958* (Vic) s 24. For a recent appeal of a conviction of a doctor under this provision, see *Peters v The Queen [No 2]* (2019) 60 VR 231.

83 There is not the space, nor the need, to go into the philosophy of the criminalisation of behaviour here — for a recent exploration of some of the issues, see Lindsay Farmer, *Making the Modern Criminal Law: Criminalisation and Civil Order* (Oxford University Press, 2016) — though, suffice it to say that the debate over the regulatory effect of the criminal law is ongoing.

84 See below Part V(C).

85 Though, of course, there is a contract between the practitioner and patient when the practitioner is in private practice.

86 A further specific category of practitioners is that of 'agency staff' — that is, where a practitioner is employed by an agency but performs work in, for example, a hospital in order to fill gaps in the institution's roster. These staff owe contractual obligations to the agency; they also are regulated, to an extent, by the institution itself. As has been noted, in circumstances like these, the employment 'status', that is, either employee or contractor, 'is not so clear': Janine McIlwraith and Bill Madden, *Health Care and the Law* (Thomson Reuters (Professional) Australia, 6th ed, 2014) 351.

take, a good as a result of a sales contract). The point here is not to elucidate all the obligations that may arise; instead, these agreements are included for two reasons. The first is the simple acknowledgement that most practitioners have voluntarily accepted constraints on their behaviour as a result of the contracts — even the most basic aspect is an example of this, with practitioners giving up their time to treat patients in return for payment. It is possible, on this point, that some clauses are in tension with other regulatory efforts[87] — if only as a result of the second point to be made. That point is that employees, specifically, owe duties to their employers over and above the explicit contractual obligations, such as the duty to comply with lawful direction.[88] This duty, when combined with the requirement that employees comply with the policies of their employer,[89] means that there may be tension between how a practitioner would prefer to interact with their patient and pressures that their employer (or the other contracting party) may place on the practitioner.[90]

IV MOTIVATED, UNGOVERNABLE HEALTH PRACTITIONERS AND THE LAW

Returning to regulatory theory, the 'key dynamic' in the decentred understanding is 'not between regulator and regulated but between multiple actors within … complex systems'.[91] This perspective, therefore, acknowledges that the state is not, necessarily, the prime promoter and enforcer of the chosen standards. This impacts on the role of law in the guiding of decisions. Further, it is possible to characterise some of the motivators as (decision-making) heuristics that would assist doctors when finalising their actions. For example, a practitioner may always return to their personal goal of trying to help others — to the extent that this factor pushes aside all others. Alternatively, their need for money may mean that they may tend to reduce the time that they spend on each patient, in order to maximise their income. That does not mean that they are not aware of their legal obligations or do not care

87 An agreement, for example, that charges the practitioner a flat fee for access to a treatment room means that a certain number of patients need to be seen in order to, first, break even and, second, turn a profit. This financial pressure may limit the time that a practitioner spends with each patient; further, the good practices that are aimed at ensuring patients are fully informed: *Code of Conduct* (n 61) cl 4.2.5; and encouraging patients to be as complete as possible in their description of their health concern may also impact on the time taken: at cl 4.3.2.

88 *Adami v Maison de Luxe* (1924) 35 CLR 143, 155 (Gavan Duffy and Stake JJ). Privileging the interests of the employer may be seen, at least to an extent, to be in conflict with the assertion that '[i]n clinical practice, the care of your patient is your primary concern': *Code of Conduct* (n 61) cl 3.1.

89 'A failure to comply with a lawful and reasonable policy is a breach of the fundamental term of the contract of employment that obliges employees to comply with the lawful and reasonable directions of the employer': *B v Australian Postal Corp* (2013) 238 IR 1, 15 [36] (Lawler V-P and Commissioner Cribb). This does not apply to independent contractors.

90 Further, there may be additional pressures from government. In South Australia, the Health Department is alleged to have encouraged surgeons to not operate on older patients and those with significant comorbidities: Isabel Dayman, 'Health Bureaucrat Urges Surgeons to "Say No" to Older, Sicker Patients', *ABC News* (online, 30 September 2020) <https://www.abc.net.au/news/2020-09-30/manager-urges-surgeons-to-say-no-to-older-sicker-patients/12717132>.

91 Ian Bartle and Peter Vaas, 'Self-Regulation within the Regulatory State: Towards a New Regulatory Paradigm?' (2007) 85(4) *Public Administration* 885, 887.

about their reputation; instead, it may be that certain motivators may unconsciously direct their behaviour. There is value, therefore, in adding practical *flesh* to both the obligations of doctors and the motivators that impact on their decisions. Five aspects, or paradigms, of the embedded nature of decisions will be discussed: money, knowledge, risk, the self-image of practitioners, and the relationships within which the decisions are made.[92] This discussion will be rounded out with an assessment of *prospective* versus *retrospective* modes of regulation.

A *Money*

To say that money impacts on behaviour is not novel. Much of its financial regulatory impact in the health system is on institutions, such as hospitals, but there is still an impact on individual practitioners.[93] The most obvious of these is that, regardless of whether practitioners are employees, contractors or sole practitioners, if they do their job, at least satisfactorily, they will get paid[94] — the obligations arising from these contracts were discussed above.[95] There is, of course, the goal to successfully treat the patient, such that the condition or symptoms dissipate — which could see the end of payment; however, a successful treatment for one issue could see the patient return when another health event occurs.[96]

A discussion of the financial consequences of less than satisfactory performance is, however, more valuable. There are two aspects to this.[97] The first is the potential

92 It may also be observed that motivators may prompt doctors to *act against* the expectations under each paradigm. Failure to treat a patient well, or to comply with legal obligations such as continuing professional development, could be the result of time pressures — with those pressures arising from commitments to comply with other legal obligations (such as those owed to their employer) or commitments to their family (proper conduct for others). Breaching obligations around drug and alcohol use may result from the positive external motivator of the intoxicants themselves: *National Law* (n 57) s 140(a). Sexual misconduct with patients, even where the patient is notionally consenting, can also be seen to be prompted by the external motivator of pleasure or power: at s 140(b).

93 'Financial and commercial dealings' are also explicitly referred to in the *Code of Conduct*: *Code of Conduct* (n 61) cl 10.13. The commentary also includes the assessment that practitioners can be overly interested in financial reward. For example, '[d]octor greed is driving bills higher': Stephen Duckett and Kristina Nemet, Grattan Institute, *Saving Private Health 1: Reining in Hospital Costs and Specialist Bills* (Report No 12, November 2019) 10 <https://grattan.edu.au/wp-content/uploads/2019/11/925-Saving-private-health-1.pdf>.

94 One study has shown that competition in the market for health service provision, and the attendant desire to provide 'value for money', impacts on the length of a doctor's consultation: Myriam Deveugele et al, 'Consultation Length in General Practice: Cross-Sectional Study in Six European Countries' (2002) 325(7362) *British Medical Journal* 472, 476.

95 That practitioners are financially self-interested is acknowledged in the law, for example, the category of 'medical entrepreneur' in the *Health Insurance Act 1973* (Cth) s 3B.

96 Though this latter point could be understood in terms of a reputational motivator — a successful treatment will improve the assessment of practitioner in the eyes of the patient.

97 There is a third, less direct, impact. For practitioners in a hospital setting, there is the potential for workplace consequences as a result of an institution's financial penalty that flows from harms suffered by a patient. A key example of this is the impact of hospital-acquired complications. Under the funding model agreed to by the states, the 'funding level for admitted acute episodes will be reduced where a hospital acquired complication … is present': Independent Hospital Pricing Authority, *National Efficient Price Determination 2018–19* (Report, March 2018) 17.

for there to be a financial impact on the practitioner, as an individual, as a result of their own conduct — including a bad treatment decision. That is, a practitioner may have their registration either limited by a condition, suspended or cancelled.[98] Either outcome means that their capacity to earn income as a practitioner is curtailed.[99] They may also be a defendant in a negligence action — though their insurer would be the entity that pays out any claim.[100] The argument here is not that the loss of income is the most significant reason to act appropriately; instead, the argument is that money is one reason, out of several, to comply with the MBA's *Code of Conduct*.[101]

The second financial arrangement, though not one that relates to the *Code of Conduct*, that impacts on practitioner conduct relates to the payments received from outside funders — whether those payments are from Medicare or from private health insurance companies.[102] Each service performed by a practitioner attracts a set fee, as long as it is listed on the '[g]eneral medical services table'.[103] If a practitioner charges more for that service than the set fee,[104] then if the patient is covered by health insurance, the insurance company may contribute to the cost of the service.[105] There is also pressure on general practitioners, in particular, to

While this reduction in funding would not be passed on to individual practitioners, the hospital may impose restrictions on a practitioner's responsibilities, or there may be an impact on the practitioner's career progression at the hospital (which would constitute a longer term financial consequence).

98 *National Law* (n 57) s 155(a). A National Board may, for example, impose a condition, or suspend a practitioner's registration as an 'immediate action' in cases where the 'Board reasonably believes that — (i) because of the registered health practitioner's conduct, performance or health, the practitioner poses a serious risk to persons; and (ii) it is necessary to take immediate action to protect public health or safety': at s 156(1)(a).

99 Loss of money would also occur if there was a period of incarceration for significant breaches of the criminal law.

100 It may be noted that studies have shown that 'tort litigation does not improve healthcare quality': David G Stevenson, Matthew J Spittal and David M Studdert, 'Does Litigation Increase or Decrease Health Care Quality: A National Study of Negligence Claims against Nursing Homes' (2013) 51(5) *Medical Care* 430, 435.

101 The possible adverse findings of the tribunal are that '(i) the practitioner has behaved in a way that constitutes unsatisfactory professional performance; (ii) the practitioner has behaved in a way that constitutes unprofessional conduct; (iii) the practitioner has behaved in a way that constitutes professional misconduct; (iv) the practitioner has an impairment; (v) the practitioner's registration was improperly obtained': *National Law* (n 57) s 196(1)(b). A breach of the *Code of Conduct*, therefore, is not the only basis for cancelling a practitioner's registration.

102 Though not all practitioners are entitled to a payment from Medicare: see generally *Health Insurance (General Medical Services Table) Regulations 2019* (Cth).

103 *Health Insurance Act 1973* (Cth) s 4. This 'fee-for-service' model may be seen to facilitate the over-servicing of patients. It may be noted that Medicare-funded practitioners may be 'disqualified' from providing services where they have been found to have engaged in inappropriate practice: at s 106U(1)(g). See also *Wong v Commonwealth* (2009) 236 CLR 573.

104 That is, there is the capacity for practitioners to charge a 'co-payment' for their services. This is not regulated by the government.

105 More specifically, '[p]rivate health insurance provides two main types of cover … hospital insurance … [and] general insurance [which] provides cover for a range of non-medical

'bulk-bill' their patients, so that no cost is incurred other than the fee as covered by Medicare. This pressure is, in part, to facilitate access to healthcare by those who cannot afford any out-of-pocket expenses.[106] The lack of additional payment may encourage practitioners to shorten the time that they spend with each patient — potentially impacting on the quality of care provided.[107]

B *Knowledge*

Knowledge is another key paradigm of regulation. There are three aspects of knowledge of relevance here.[108] The first is that which relates to the practitioner themselves; the second relates to the knowledge of the discipline within which the practitioner practices; and the third highlights the links between knowledge and decision-making theory.

The register of practitioners operates as a record of data that allows others to form an opinion about the registered individual.[109] The information includes (a) where the practitioner received their qualifications; (b) how long they have been registered; (c) the type of registration;[110] (d) any endorsements (such as where a nurse is registered as a nurse practitioner); (e) any conditions that have been imposed on their registration; (f) any reprimands that they have received as a result of an investigation into their conduct;[111] and (g) any suspensions of registration.[112] Taken together, the entries give the person accessing the record an idea of the practitioner. This idea would impact on how the person who accessed the register would engage with the practitioner. In other words, the information contained in the register about each practitioner is, to an extent, reputational and linked, therefore, to the reputational motivators. In addition, there are reputational

services': Stephen Duckett and Kristina Nemet, 'The History and Purpose of Private Health Insurance' (Working Paper No 2019-05, Grattan Institute, July 2019) 7. Insurers, however, do not cover visits to general practitioners.

106 Advertising as a bulk-billing practice may also operate to draw more patients to the practice than might otherwise come, if no other practices in the area bulk-billed.

107 For an economic analysis of this, linking consultation times, bulk-billing and the level of competition in the market, see Hugh Gravelle et al, 'Competition, Prices and Quality in the Market for Physician Consultations' (2016) 64(1) *Journal of Industrial Economics* 135.

108 The *Code of Conduct* (n 61) also refers to knowledge — both in terms of the practitioner having 'adequate knowledge and skills': at cl 3.2.2; and gaining sufficient information about the patient, their condition and their history: at cl 3.1.1.

109 The registers are publicly available (eg, via the AHPRA website, accessible from the homepages of the National Boards); and so, potential patients can also view the information: see Australian Health Practitioner Regulation Agency, 'Look up a Health Practitioner', *AHPRA and National Boards* (Web Page) <https://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx>. It is not clear, however, how many members of the public do.

110 Whether they are registered in the general, specialist, student, or limited categories. Further, a career that includes a specialisation can also be seen as both reputational (in terms of standing out from the non-specialists), and as reflecting a form of proper conduct for the self (in terms of understanding more about the human body and its operation).

111 Reprimands may be issued by a 'performance and professional standards panel': *National Law* (n 57) s 191(3)(c); or a 'responsible tribunal': at s 196(2)(a).

112 Ibid s 225.

consequences that may result from non-compliance with their legal obligations. Any desire to not have reprimands made, or worse, listed relates to a desire to not have potential patients think worse of them.[113]

Second, all practitioners limit their behaviour in light of their profession. This is an unsurprising observation given the need for a practitioner to have received a formal qualification before they can be registered. Further, as mentioned above, practitioners need to maintain their knowledge of their discipline in order to stay registered. The need for currency reflects the fact that knowledge, such as preferred treatment modalities for a given presentation, changes over time. Two points may be made here. First, there is not always a single, preferred, treatment option. The relevance to this for assessing negligence has already been referred to. As such, any particular piece of knowledge may not have a totalising impact on a practitioner's behaviour as there always may be an alternative *approved* practice available to them. Second, non-practitioners have a role in the development of new disciplinary knowledge. Again, this is unsurprising given the role that universities and other research centres (including those of multinational pharmaceutical companies) have in generating new understandings of the body and novel treatments. The point here is that researchers, some public- and some private-funded, impact on the decisions made by practitioners — as such, those who develop new medical knowledge are a part, albeit indirectly, of the regulatory regime for healthcare practitioners.

Finally, knowledge plays a specific role in decision-making theory. With respect to ideas of naturalistic decision-making, the importance of knowledge matches the focus in the theory on expertise.[114] Past experience, to the extent it impacts on their decisions, also falls under the same paradigm. The risks associated with time pressures, and the deferral to the expertise of others (including specialists), also fit the model. These factors are built into the thought processes of the practitioners — again, it is their professional *proper conduct* to base their decisions on knowledge and experience. That said, the application of the theory still suggests that they may try to *match* specific features of the patient seeing them with similar patients in the past. While this is not an ideal form of decision-making, this form of *habitual rationality* does save time and mental load.

113 It may be noted that, for some patients, the amount of information on the register is not enough to gain a sufficient understanding of the practitioner. The register, for example, does not include incidents where the practitioner has been sued, but where the insurance company settled without an admission of liability: see, eg, Sophie Scott and Rebecca Armitage, 'Patient Whose Breast "Exploded" after Implant Surgery Calls for Greater Transparency of Doctor's History', *ABC News* (online, 10 August 2016) <https://www.abc.net.au/news/2016-08-10/calls-for-transparency-of-doctors-legal-settlement-history/7704520>.

114 Examples of the application of naturalistic decision-making ideas to health decisions include: Thierry Morineau et al, 'Decision Making During Preoperative Surgical Planning' (2009) 51(1) *Human Factors* 67; Roni Reiter-Palmon et al, 'Naturalistic Decision Making in After-Action Review Meetings: The Implementation of and Learning from Post-Fall Huddles' (2015) 88(2) *Journal of Occupational and Organizational Psychology* 322. In the area of nursing: see Christine W Nibbelink and Barbara B Brewer, 'Decision-Making in Nursing Practice: An Integrative Literature Review' (2018) 27(5–6) *Journal of Clinical Nursing* 917.

C *Risk*

The third aspect to be discussed, risk, can be seen as more amorphous than the first two. That said, the use of the concept here is more limited than its more political understanding.[115] More specifically, its importance is acknowledged in the *Code of Conduct*:

> Risk is inherent in healthcare. Minimising risk to patients is an important component of medical practice. Good medical practice involves making patient safety your first priority and understanding and applying the key principles of risk minimisation and management in your practice.[116]

As such, risk, its assessment and management, is something that should impact on the decisions of practitioners.[117]

In particular, practitioners have to be aware of the risks that attach to different treatment options.[118] Risk, therefore, is necessarily tied to the operationalisation of the knowledge possessed by doctors. The practitioners should acknowledge that there are risks attached to any prognosis. There are also risks associated with non-payment (though this is less of an issue for Medicare-funded procedures) and there is also no certainty that, should they engage in misconduct or make any mistakes, they will be subject to any disciplinary action. As such, risk is value neutral — it relates only to an acknowledgement that a particular outcome is not guaranteed to occur.[119] The point, here, being that any uncertainty should be factored into any treatment decision of practitioners.

Decision-making theory offers further insights into the role of risk in the decisions of practitioners. For example, the 'satisficing' approach from the bounded rationality model reflects an acceptance of some of the risks associated with treatment decisions.[120] A practitioner cannot wait until all aspects of the patient's condition are known (if only because, for many conditions, the patient may improve without any intervention) before deciding on a treatment. With respect to biases, a key way in which they impact on decisions is that people 'tend to rely on their cognitive availability' about a possible outcome, rather than deciding in terms of the 'actual likelihood of the event occurring'.[121] The example provided by the authors was that 'if a certain rare diagnosis comes to mind easily because a

115 Beck, for example, coined the term 'risk society' to privilege the understanding that the production of risk accompanies the production of wealth in society: Ulrich Beck, *Risk Society: Towards a New Modernity*, tr Mark Ritter (Sage Publications, 1992) 19.

116 *Code of Conduct* (n 61) cl 8.1.

117 For a discussion of decision-making and risk, see Daniel Kahneman and Amos Tversky, 'Prospect Theory: An Analysis of Decision under Risk' (1979) 47(2) *Econometrica* 263; Dilip Soman, 'Framing, Loss Aversion, and Mental Accounting' in Derek J Koehler and Nigel Harvey (eds), *Blackwell Handbook of Judgment and Decision Making* (Blackwell Publishing, 2004) 379.

118 Such as discussed in *Rogers v Whitaker* (1992) 175 CLR 479, 483 ('*Rogers*').

119 With the outcome in question being either positive or negative.

120 See above n 35 and accompanying text.

121 Stiggelbout, de Vries and Scherer (n 56) 777.

physician has recently treated a striking case with that particular diagnosis, this physician may fall prey to the availability bias and overestimate the likelihood of that diagnosis in future cases'.[122] This can be linked with 'optimism biases', which are 'interrelated' with 'overconfidence' and 'wishful thinking'.[123] That is, if, in the decision-maker's experience, negative outcomes have not followed particular actions, then their mind is more likely to underplay the risks of such outcomes.[124]

D *Self-Image*

Tied to these biases is the idea that practitioners have a particular view of themselves — both when they are acting in their capacity as doctors and when they are not (though, of course, the focus here is on the former). Any sense of overconfidence, by definition, indicates an overly positive self-image. Other regulatory aspects of self-image include the 'proper conduct for the self' motivator discussed above; that is, a practitioner will act in a certain way, when dealing with patients — because that is how they see themselves (which could be as simple as being cheerful or reserved).

What is yet to be discussed is the issue of the personal morality of practitioners. This is distinct from the 'internal morality' of the profession.[125] The latter form of morality is tied to the professional ethics (for example, the MBA's *Code of Conduct*, World Medical Association's Codes of Ethics,[126] and guidelines such as

122 Ibid, citing Roy M Poses and Michele Anthony, 'Availability, Wishful Thinking, and Physicians' Diagnostic Judgments for Patients and Suspected Bacteremia' (1991) 11(3) *Medical Decision Making* 159; Sílvia Mamede et al, 'Effect of Availability Bias and Reflective Reasoning on Diagnostic Accuracy among Internal Medicine Residents (2010) 304(11) *Journal of the American Medical Association* 1198.

123 Paul D Windschitl and Jillian O'Rourke Stuart, 'Optimism Biases: Types and Causes' in Gideon Keren and George Wu (eds), *The Wiley Blackwell Handbook of Judgment and Decision Making* (Wiley Blackwell, 2015) vol 1, 431, 432 (emphasis omitted). One analysis lists a number of biases that may impact on clinical decisions — '[c]ommission bias', '[a]ttribution bias', '[i]mpact bias, affect bias and framing effects', '[a]vailability bias', '[a]mbiguity (uncertainty) bias', '[r]epresentativeness (extrapolation) bias', '[e]ndowment effects and default (status quo) bias', '[s]unken cost (vested interest) bias' and 'biases peculiar to groups': Ian A Scott et al, 'Countering Cognitive Biases in Minimising Low Value Care' (2017) 206(9) *Medical Journal of Australia* 407, 407–8. Another notes that '[a]lthough cognitive biases may affect a wide range of physicians … their true prevalence remains unknown': Gustavo Saposnik et al, 'Cognitive Biases Associated with Medical Decisions: A Systematic Review' (2016) 16 *BMC Medical Informatics and Decision Making* 138:1–14, 12.

124 For a discussion of the role of overconfidence in doctors' decisions, see Eta S Berner and Mark L Graber, 'Overconfidence as a Cause of Diagnostic Error in Medicine' (2008) 121(5A) *American Journal of Medicine* S2. For a discussion of the role of groups, which could include the professional colleagues of doctors, in fostering overconfidence, see Joey T Cheng et al, 'The Social Transmission of Overconfidence' (2021) 150(1*) Journal of Experimental Psychology: General* 157.

125 One study discusses 'internal morality' as 'those values, norms, and rules that are intrinsic to the practice of medicine' and 'external morality' as 'the view from outside, reflecting the ethos of the wider society': Charlotte Paul, 'Internal and External Morality of Medicine: Lessons from New Zealand' (2000) 320(7233) *British Medical Journal* 499, 499 (citations omitted).

126 'WMA International Code of Medical Ethics', *World Medical Association* (Web Page, 9 July 2018) <https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/>.

those for sexual relationships between doctors and patients[127]); however, an individual's morality may go further.[128] In many cases, the morality may be linked with an organised religion, but it does not have to be. To the extent that the morals are co-extensive with professional ethics, any breaches may be subject to the legal controls discussed above. The focus here, instead, is on morals outside such ethics.

Personal morality itself garners much less attention, outside specific realms such as abortion and euthanasia,[129] than does professional ethics.[130] That said, where it is raised, it has been asserted that '[p]rofessionals as well as patients have a right to live by their personal moral values'.[131] As an example, a surgeon is reported to have refused to operate, in the 1980s, on a patient who refused to take an HIV test, saying '[l]ots of surgeons carry antibodies for hepatitis B. That's a risk we all have taken, but I won't take the chance of bringing AIDS into my bed and killing my wife'.[132]

His conscience meant that he felt that he had to privilege the interests of his wife over that of the patient.[133] Abstracting this allows for the assessment that a violation of one's conscience (whether as a practitioner or member of the broader community) 'would result not only in such unpleasant feelings as guilt and/or shame but also in a fundamental loss of integrity, wholeness, and harmony in the self'.[134] Personal morality, then, is a strong pressure on some behaviours in the health system. There is, as a result, further scope for interaction when morals and legal obligations conflict — in addition to the concept of conscientious objection to be discussed below.

127 'Sexual Boundaries in the Doctor-Patient Relationship', *Medical Board of Australia* (Web Page, 20 July 2020) <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Sexual-boundaries-guidelines.aspx>.

128 There is, of course, significant discussion of the relationship between ethics and morality in the health professions: see, eg, Rosamond Rhodes, 'Why Not Common Morality?' (2019) 45(12) *Journal of Medical Ethics* 770; Edmund D Pellegrino, 'The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions' (2001) 26(6) *Journal of Medicine and Philosophy* 559.

129 See below Part V(A).

130 There are instances, too, where morals are raised and then ignored — for example, the 'law might seem to require a doctor to behave in a way which conflicts with his or her personal morality': Emily Jackson, 'The Relationship between Medical Law and Good Medical Ethics' (2015) 41(1) *Journal of Medical Ethics* 95, 95.

131 Thomas May and Mark P Aulisio, 'Personal Morality and Professional Obligations: Rights of Conscience and Informed Consent' (2009) 52(1) *Perspectives in Biology and Medicine* 30, 37.

132 Norman Daniels, 'Duty to Treat or Right to Refuse?' (1991) 21(2) *Hastings Center Report* 36, 36.

133 The surgeon knew that someone else, a surgeon without the same capacity to refuse, would carry out the operation: ibid.

134 James F Childress, 'Appeals to Conscience' (1979) 89(4) *Ethics* 315, 318. This characterisation makes clear the connection between morals and proper conduct for the self.

E *Relationships*

The final paradigm to be considered here is the fact that all decisions are made in the context of a specific relationship.[135] The key relationship for treatment decisions is the one that the practitioner has with the patient concerned,[136] with the *Code of Conduct* devoting a section to the '[d]octor-patient partnership'.[137] Others of interest from a regulatory perspective include relationships with pharmaceutical companies;[138] however, for reasons of space, they will not be discussed in depth here. There are, nonetheless, two aspects of the practitioner-patient relationship that need to be raised.[139]

The first, relating to the purpose of their vocation, the practitioner's desire to improve their patients' health. This, therefore, fits the two internal motivators: a practitioner may fulfil their obligations simply because they see themselves as the kind of person who does what they should, and the treatment process is almost the archetypal *proper conduct for others* — the essence of their profession is prosocial in that they treat people to help their patients get better or to help them to lead healthier lives. This therapeutical purpose is referred to in the *Code of Conduct* — for example, 'the care of your patient is your primary concern'.[140] This, of course,

135 This is backed up by psychology. For a discussion of treatment decisions as 'shared decisions', in a context of naturalistic decision-making, see Ronald Mark Epstein, 'Whole Mind and Shared Mind in Clinical Decision-Making' (2013) 90(2) *Patient Education and Counseling* 200. Another study highlights that '[s]tudies of medical decision making as a shared activity were occurring long before patient centred care was formally incorporated into healthcare policy': Paul R Falzer and D Melissa Garman, 'Image Theory's Counting Rule in Clinical Decision Making: Does It Describe How Clinicians Make Patient-Specific Forecasts?' (2012) 7(3) *Judgment and Decision Making* 268, 278, citing Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (National Academy Press, 2001).

136 Another set of relationships is also acknowledged in the *Code of Conduct* (n 61) — for example '[w]orking with healthcare professionals': at cl 6.

137 Ibid cl 4.2.

138 Concerns have been raised about the practices that pharmaceutical companies adopt to provide information to practitioners about the drugs that they sell: see, eg, Freek Fickweiler, Ward Fickweiler and Ewout Urbach, 'Interactions between Physicians and the Pharmaceutical Industry Generally and Sales Representatives Specifically and Their Association with Physicians' Attitudes and Prescribing Habits: A Systematic Review' (2017) 7(9) *BMJ Open* e016408:1–12. For an analysis of the Australian experience, see Alice Fabbri et al, 'A Cross-Sectional Analysis of Pharmaceutical Industry-Funded Events for Health Professionals in Australia' (2017) 7(6) *BMJ Open* e016701:1–8. It has been suggested, however, that any impact of the industry's practices will be small, given all the other factors at play — a German study, for example, found that '[i]f the patient numbers at a practice are taken into consideration, the significant effects of the frequency of [pharmaceutical sales representative] visits on prescribing behaviour were found to disappear, sometimes even completely': Klaus Lieb and Armin Scheurich, 'Contact between Doctors and the Pharmaceutical Industry, Their Perceptions and the Effects on Prescribing Habits' (2014) 9(10) *PLoS One* e110130:1–8, 4.

139 A third aspect that could be explored relates to the processes through which a patient can complain about the actions of a doctor. While doctors may make decisions in light of the potential for complaints, that aspect will not be discussed further here: see generally Carney et al (n 57). The role of another key form of reducing the chance of 'pushback' from patients, defensive medicine, will be discussed further below: see below Part V(B).

140 *Code of Conduct* (n 61) cl 3.1.

has a tradition that goes back centuries. The Hippocratic Oath, for example, holds, in part, that 'I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone'.[141] Few practitioners would dispute that this oath operates as a framework that guides, or at least should guide, their treatment decisions — though the oath itself has little legal effect.[142]

The other aspect includes the requirements around the gaining of consent of the patient before any treatment can take place.[143] While this can be seen purely as a legal requirement, albeit one that focuses on the patient, it may be better understood as a *process*, based on ethics, that is constituted by the patient-practitioner relationship.[144] Further, while the tests focus on the patient — including whether they have the capacity to make the decision[145] and whether the decision was voluntary[146] — the obligation, both legal and ethical, is on the practitioner to ensure that the tests are satisfied. In particular, the practitioner has to ensure both that they do not place too much pressure on the patient[147] and that the practitioner provides as much information as is adequate[148] — considering the state of mind of the patient and the weight the patient will attach to any relayed risks.[149] The law of consent, now, fits a 'patient-centred' view of medical practice;[150] as such, it is a shift away from more paternalistic understandings of the process. The *Code of Conduct* emphasises that treatment is based on the 'relationship', and indeed the 'partnership', between the practitioner and patient;[151] therefore, all treatment decisions should be made under this paradigm.

F *Prospective vs Retrospective Regulation*

One conclusion that may be drawn from these aspects of regulation is that most are *prospective* — in the sense that they provide the basis for the decisions to be

141 Reproduced in Sonia Allan and Meredith Blake, *The Patient and the Practitioner: Health Law and Ethics in Australia* (LexisNexis Butterworths, 2014) 28, citing Ludwig Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation* (John Hopkins Press, 1943) 3.

142 *Nitschke v Medical Board of Australia [No 1]* (2015) 36 NTLR 55, 90 [124] (Hiley J).

143 'Consent ordinarily has the effect of transforming what would otherwise be unlawful into accepted, and therefore acceptable, contact': *Secretary, Department of Health and Community Services v JWB* (1992) 175 CLR 218, 233 (Mason CJ, Dawson, Toohey and Gaudron JJ).

144 The *Code of Conduct* (n 61) provisions state that 'consent is a person's voluntary decision about medical care': at cl 4.5; and that '[g]ood medical practice involves … [p]roviding information to patients in a way they can understand': at cl 4.5.1.

145 See, eg, *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290, 292 (Thorpe J).

146 See, eg, *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 121 (Staughton LJ).

147 This can be derived from the broader requirement that practitioners should '[e]nsur[e] [that their] personal views do not adversely affect the care of [their] patient': *Code of Conduct* (n 61) cl 3.2.14.

148 See, eg, *Rosenberg v Percival* (2001) 205 CLR 434, 461 [86] (Gummow J).

149 See, eg, *F v R* (1983) 33 SASR 189, 192–3 (King CJ).

150 *Code of Conduct* (n 61) cl 2.1.

151 Ibid cl 4.1.

made. A smaller number, instead, can be seen as retrospective — in that they are applied to decisions that have already been made. This brief discussion highlights that the former may be better characterised as systems that establish norms of behaviour; whereas the legal rules, when the basis of a legal complaint,[152] are ex post facto attempts at calling out, and/or punishing, bad behaviour (or, in the language of this article, negative external motivators).

Those aspects discussed here that do not have a set of sanctions that directly apply are most obviously norms. In this context, norms are standards of conduct that are 'the common measure' of behaviour within a group and the 'modern form of the social bond'.[153] There is no legal requirement to make money; however, that is a key part of the motivation of doctors to practise (and, of course, of other professions too). These aspects, then, pre-exist each decision and operate as part of the context of every interaction between the doctor and their patients.

Even those with sanctions that could be applied can be seen as norms. That is, while there is a retrospective aspect to compliance with the *National Law* (such as through the professional misconduct provisions)[154] and the *Code of Conduct*, the specific provisions reflect the ingrained practices of the profession. For example, if consent is not gained from a patient, there are legal ramifications; however, the practices around seeking consent have been (almost completely)[155] internalised. In other words, the legal obligations, qua sanctionable requirements, may not be at the forefront of the minds of the practitioners when treating patients.

Expressed differently, they seek consent (along with features of the requisite standard of care) as a matter of habit.[156] Tying this in with decision-making theory, while on reflection, practitioners would know that they are under legal obligations,

152 Whether civil (eg, negligence), administrative (eg, under the National Law), or criminal.

153 François Ewald, 'Justice, Equality, Judgement: On "Social Justice"' in Gunther Teubner (ed), *Juridification of Social Spheres: A Comparative Analysis in the Areas of Labor, Corporate, Antitrust and Social Welfare Law* (Walter de Gruyter, 1987) 91, 108 (emphasis omitted). The idea of norms being embedded in the communities is evident in the assessment that 'culture' can have an 'influence' on 'decision-making': see, eg, Nibbelink and Brewer (n 114) 926.

154 See, eg, *National Law* (n 57) s 136.

155 The internalisation is not complete as there is evidence that a patient's capacity for consent is not always assessed fully. One study, for example, found that '[o]ver one quarter of medical or surgical hospital inpatients lack the mental capacity for hospital treatment decisions': R Murphy et al, 'Who Can Decide: Prevalence of Mental Incapacity for Treatment Decisions in Medical and Surgical Hospital Inpatients in Ireland' (2018) 111(12) *Quarterly Journal of Medicine* 881, 883. If the patients do not have capacity, then there is little basis for the doctors' assessments of the patients' wishes. The study, in turn, cites research to the effect that '[i]n England, up to 40% of acute medical inpatients lack the mental capacity for key treatment decisions': at 881, citing Vanessa Raymont et al, 'Prevalence of Mental Incapacity in Medical Inpatients and Associated Risk Factors: Cross-Sectional Study' (2004) 364(9443) *Lancet* 1421; Gareth S Owen et al, 'Decision-Making Capacity for Treatment in Psychiatric and Medical In-Patients: Cross-Sectional, Comparative Study' (2013) 203(6) *British Journal of Psychiatry* 461.

156 In the same way that a 'physician acquires a volitional habit of taking the pulse and asking patients certain questions. The habit is the familiar way in which his consciousness runs its course during a diagnosis': B R Andrews, 'Habit' (1903) 14(2) *American Journal of Psychology* 121, 121, quoted in Marc D Ginsberg, 'Habit Forming: Evidence of Physician Habit in Medical Negligence Litigation' (2019) 19(1) *Yale Journal of Health Policy, Law, and Ethics* 215, 218.

the actual requirements may be *automatised*.[157] They are carried out, not because it is the law, but because those are the practices that they should demonstrate as a good practitioner.[158] This also, then, returns to the notion of *proper conduct* — the idea of doing things the way that they should be done. Complying with the norms of good medical practice is a prospective mode of regulation, even when the norms are linked with legal obligations. Of course, norms are as capable of being transgressed as law; the balance of this article considers problematic decisions made by practitioners in terms of these internal aspects of their work.

V CHALLENGING EXAMPLES AROUND REGULATING TREATMENT DECISIONS

This understanding of medical decisions may now be expanded upon through a discussion of four scenarios. To be clear, the use of the paradigms, motivators and decision-making theory only goes to better understanding the decisions of practitioners and not, directly, to their greater regulation. That is, the goal is to provide further context to the internal aspects of the *ungovernable* individual. The four scenarios are: conscientious objection, defensive medicine,[159] medical errors and active placebos.

A *Conscientious Objection*

This first *challenging* example may not be seen to be problematic because the system already accommodates it. The principle of *conscientious objection* allows a practitioner to not participate in a given treatment for a patient, on the basis that the treatment goes against the doctor's conscience. As such, the self-image of the doctor is privileged over *proper conduct* as evidenced in the Hippocratic Oath.[160]

An obvious example is captured in s 7 of the *Voluntary Assisted Dying Act 2017* (Vic).[161] Under that provision, a practitioner has the 'right to refuse', inter alia, to 'provide information about voluntary assisted dying'; to 'participate in the request and assessment process'; and to 'supply, prescribe or administer a voluntary assisted dying substance' as long as they have a 'conscientious objection'.[162] A more restricted instance is found in s 8 of the *Abortion Law Reform Act 2008* (Vic).

157 Expressed differently, '[m]uch of everyday clinical decision-making is largely intuitive behaviour guided by mindlines (internalised tacit guidelines on how to manage common problems) and heuristics': Scott et al (n 123) 1 (citations omitted).

158 Such that aspects of the legal frameworks that provide the context of their decisions, like the criminal law, do not need to enter into their minds.

159 While in one study, the authors only found 'systematic evidence of defensive medicine' in the United States of America ('USA') and the United Kingdom ('UK'), they did not rule out the existence of the practices in Australia: Daniel P Kessler, Nicholas Summerton and John R Graham, 'Effects of the Medical Liability System in Australia, the UK, and the USA' (2006) 368(9531) *Lancet* 240, 240.

160 See above n 139.

161 There is a similar provision in s 9 of the *Voluntary Assisted Dying Act 2019* (WA).

162 'Conscientious objection', however, is not defined in the *Voluntary Assisted Dying Act 2017* (Vic).

Here, the practitioner must 'inform the woman that the practitioner has a conscientious objection to abortion; and refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion'. The only reference to such objections in the MBA's *Code of Conduct* is that 'good medical practice' includes:

> Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues of your objection, and not using your objection to impede access to treatments that are legal. In some jurisdictions, legislation mandates doctors who do not wish to participate in certain treatments, to refer on the patient.[163]

This provision, then, seeks to minimise the impact of the right on the care of the patient.

The two examples of conscientious objection focus on the tension between the desires of the patient and the deliberate termination of a life.[164] The acknowledgement of the right to object is not surprising given that there has not been a 'moral consensus' on the topic 'among healthcare professionals or the general public'.[165] There is, however, further discussion in the literature that suggests some practitioners object, on the basis of their conscience, less controversial aspects of healthcare. Wicclair, for example, refers to a practitioner who believes that they have an 'ethical obligation to do what [they] can to prevent, or at least postpone' a patient's death — even when the mentally competent patient has expressed the clear desire to forgo treatment and enter a hospice.[166] The practitioner's belief privileges their perception of their interests over those of the patient.

Conscientious objection, more broadly, allows practitioners, particularly those with 'specialized knowledge' to occupy a position that 'usurp[s] the moral judgment of the … patient by presenting (or neglecting) information in a way that undermines the … patient's ability to apply his or her own moral or religious value system'.[167] Noting, first, the role of *knowledge* in this assessment, it also raises the relative importance of the internalised norms of the practitioner. The legislative

163 *Code of Conduct* (n 61) cl 3.4.6.

164 Acknowledging the issues of attributing life to an embryo or foetus that is viable outside the womb.

165 Mark R Wicclair, 'Conscientious Objection in Medicine' (2000) 14(3) *Bioethics* 205, 206. This article is, of course, not Australian. As, however, noted by the Australian Medical Association's ('AMA') submission to the Assisted Dying reform process in Victoria: 'There are widely disparate views on the matters of physician assisted dying and euthanasia within AMA Victoria's membership, the medical profession as a whole, and across the Victorian community': Australian Medical Association Victoria, 'Physician Assisted Dying' (Position Statement, 6 December 2016) 2 <https://amavic.com.au/policy-and-advocacy/media/Archived-Media-Releases/2016-media-releases/position-statement-on-physician-assisted-dying>.

166 Wicclair (n 165) 207–8.

167 May and Aulisio (n 131) 35. This analysis was done in the context of what practitioners should disclose in order to gain a patient's informed consent.

provisions, where they exist, allow the doctors to decide with their self-beliefs, with some acknowledgement of their impact on the patients (that is, the law accommodates these certain personal views of practitioners). The extent to which practitioners *conscientiously object* to patients' wishes in other circumstances, such as those described by Wicclair, is unclear.[168]

While conscientious objection, as expressed in statute, may be understood in terms of mainstream religion, in principle, other internalised norms could be the basis of an objection. Wicclair limits his analysis to those 'core ethical values … [that are] central to the physician's self-image … and, hence, moral integrity'[169] — but that, itself, is a value judgment. Sincerely held decisions, such as those based on the efficient use of scarce resources, could/should be just as protectable as those acknowledged in the Voluntary Assisted Dying Acts. The acknowledgements that not all patients can be treated to the same level (this becomes particularly obvious the larger the population that is considered), and therefore that treatment has to be rationed, is still public-spirited and may accord with a practitioner's self-image. It is not clear, however, that the right to refuse to treat some patients for the good of others will be enshrined in legislation.[170]

B *'Defensive Medicine' and Decision-Making*

The second example of problematic decision-making to be discussed is *defensive medicine*. By way of an overview, '[d]efensive medicine can be defined as changes in practice that are induced by the threat of liability, are not cost-justified, and not simply the result of insurance induced moral hazard'.[171] Obviously, here the potential for liability is seen as an external, negative motivator.[172] Further, '[d]efensive medicine may supplement care (eg, additional testing or treatment), replace care (eg, referral to another physician or health facility), or reduce care (eg, refusal to treat particular patients)'.[173] The most obvious link with the framework discussed here is with *risk*. That is, defensive medicine strategies have been said

168 There is also the possibility that patients agree with doctors, even when it is not in accordance with the patient's wishes — for example, 'the pressure [on the patient] to provide an affirmative answer authorising unwanted medical intervention is very powerful … particularly, when the motive for interfering with [autonomy] is understandable, and indeed to many would appear commendable': *St George's Healthcare NHS Trust v S* [1999] Fam 26, 46–7 (Judge LJ).

169 Wicclair (n 165) 221.

170 The counterpoint, though, is the argument that there should be a duty to treat all and sundry who come into the practitioners' 'neighbourhood', regardless of the physicians' wishes. For a further discussion of this, see Daniels (n 132) 41–5.

171 Adrian Towse and Patricia Danzon, 'Medical Negligence and the NHS: An Economic Analysis' (1999) 8(2) *Health Economics* 93, 97.

172 Studies have shown, however, that concerns around possible litigation can have both positive and negative impacts on practitioners: see, eg, Louise Nash et al, 'GPs' Concerns about Medicolegal Issues: How It Affects Their Practice' (2009) 38(1–2) *Australian Family Physician* 66, 66; Louise Nash et al, 'Perceived Practice Change in Australian Doctors as a Result of Medicolegal Concerns' (2010) 193(10) *Medical Journal of Australia* 579, 582.

173 David M Studdert et al, 'Defensive Medicine among High-Risk Specialist Physicians in a Volatile Malpractice Environment' (2005) 293(21) *Journal of the American Medical Association* 2609, 2609.

to have been adopted in order to reduce the risk of litigation.[174] The existence of risk does not drive the content of a treatment decision, though additional testing may also reduce the risk of decisions being made based on incomplete information. Finally, referring on a patient may limit the chance that the doctor will be held responsible for the outcome experienced by the patient.

The risk of litigation, of course, goes to *money* as locus of regulation.[175] While practitioners do not pay any compensation personally, fewer suits mean lower insurance premiums — an assessment that may simply suggest the need for more evidence, or one that links with a negative external motivator, such as an aversion to financial imposts. Additional testing and treatment may also result in fewer mistakes, and a reduced chance of a notification that could lead to a suspension or cancellation of their registration. Depending on the arrangements involving the doctor's practice, there could also be positive financial benefits that arise from requesting more tests.[176] The inclusion of additional, and potentially unnecessary, testing as a strategy supports the idea that *knowledge* frames the decisions of doctors — though a concern around defensive medicine is that it suggests that, in some cases, too much knowledge is sought before a decision is made.

Finally, with respect to *relationships*, practitioners engaged in defensive medicine can be seen to be either limiting their relationships (where they refer the patient on) or acting in the knowledge that treatment happens within a relationship. It is an obvious point, but the doctors are making the decision based on their understanding of the specific person — and not just a generic patient. That is, their knowledge of, and the risks associated with, that patient, their needs and the perceived likelihood of any recourse to redress frames the options offered by the practitioner. There may be less need for defensive medicine, but for the nature of the person in the treatment room.

174 This has been backed up experimentally — 'evidence shows that when malpractice liability pressure is at play, physicians increase the provision of medical services for their patients, regardless of the patients' severity and the physicians' payment system': Massimo Finocchiaro Castro et al, 'Medical Malpractice Liability and Physicians' Behavior: Experimental Evidence' (2019) 166 (October) *Journal of Economic Behavior and Organization* 646, 658.

175 There are limits to any concern doctors may have with respect to litigation. An example of this is the willingness of some anaesthetists to permit day surgery patients to leave the facility without being under the supervision of a responsible person. For a description of the professional advice, see Royal Australasian College of Surgeons, Australian and New Zealand College of Anaesthetists and Australian Society of Plastic Surgeons, 'Day Surgery in Australia' (Position Paper, October 2017) <www.surgeons.org/-/media/Project/RACS/surgeons-org/files/position-papers/2017-10-09_pos_fes-pst-061_day_surgery_in_australia.pdf>. For a discussion of its prevalence, albeit in another jurisdiction, see Frances Chung et al, 'Frequency and Implications of Ambulatory Surgery without a Patient Escort' (2005) 52(10) *Canadian Journal of Anesthesia* 1022.

176 While, in Australia, many pathology laboratories are independent from medical practices, there is a category of pathology services that has '[p]remises comprising a laboratory … render[ing] a limited range of pathology [services]' and 'under the … direction, control and supervision of … a medical practitioner', being services 'only for the patients of [the] medical practice … operated by, or [that] employs, the [medical practitioner]', where the medical practice 'is co-located with the laboratory': *Health Insurance (Accredited Pathology Laboratories — Approval) Principles 2017* (Cth) s 17(1).

The key aspect of defensive medicine, however, is that it is, to a significant extent, strategic (and so, to an extent at least, it operates prospectively on the minds of practitioners). Certain actions are taken in order to avoid potential future events. This reinforces the idea that not all decisions by doctors are *fast and frugal* — though, over time, the desire to avoid risks may become automatised or habitual. Such strategic decisions, nonetheless, fit the idea that doctors are faced with a range of motivations when deciding. Those who practice medicine are expressing preferences with respect to positive and negative external incentives, and they may be privileging the avoidance of sanctions over their prosocial character, or their desire for a particular reputation amongst potential patients. A recent call for reform in the area alludes to these aspects — highlighting the 'powerful motivators that incentivize defensive practice' and the need to change the 'views' that assess defensive medicine as 'acceptable or unavoidable'.[177] While the present article is not specifically arguing for change with respect to defensive medicine, it is arguing for a more complete understanding of the regulation of doctors' decisions which accommodates a broader view of decisions that give rise to practices like defensive medicine.

C *Deaths from Dosage Errors — 'Automatised' Decisions or Inattention?*

Not all medical decisions, however, are as strategic. This third example assumes that some are not fully thought through[178] — or that mistakes happen through inattention (a lack of clear decision). By way of background, studies show that significant numbers of deaths can be attributed, at least in part, to practitioner error. It has been claimed that 'more than 18,000 people die in Australia from "avoidable medical adverse events"'.[179] It appears, however, as if the chance of a practitioner being criminally charged, despite death being an outcome, is very small. The issue for discussion here is that whether such an approach, where the error is a brief lapse

177 Johan Christiaan Bester, 'Defensive Practice is Indefensible: How Defensive Medicine Runs Counter to the Ethical and Professional Obligations of Clinicians' (2020) 23(3) *Medicine, Health Care and Philosophy* 413, 419 (citations omitted).

178 That said, it has been acknowledged that 'heuristics can also serve as strengths … [f]or example, the representativeness heuristic, which refers to the assessment of probability based on similarities between the current case and a model, allows medical personnel to efficiently make diagnostic decisions that are more often correct than not': Blumenthal-Barby and Krieger (n 5) 550.

179 Ian Dobinson, 'Medical Manslaughter' (2009) 28(1) *University of Queensland Law Journal* 101, 101, citing Tracy Bowden, 'The Danger in Australian Hospitals', *ABC News* (online, 4 March 2002) <http://www.abc.net.au/7.30/content/2002/s496140.htm>, archived at <https://web.archive.org/web/20100119002319/http://www.abc.net.au/7.30/content/2002/s496140.htm>. More generally, according to the Australian Bureau of Statistics, in 2016, 196 people died as a result of 'complications of medical or surgical care' (this included examples in which 'misadventure' was identified): Australian Bureau of Statistics, *3303.0: Causes of Death, Australia, 2016* (Archived Issue, 25 September 2018) <https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3303.02016?>. A 2013 USA study provides a significantly higher number of up to 400,000 patients dying each year from preventable harm: John T James, 'A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care' (2013) 9(3) *Journal of Patient Safety* 122, 127. This would equate to up to 30,000 deaths in Australia — though the differences in treatment practices across the two countries may vary this figure to an extent.

in either focus or thought, is ideal, or whether there is an alternative that could be adopted.

While it may seem incongruous, the decisions of doctors may be compared with those of car drivers. For both, there are a large number of independent individuals, operating within a complex regulatory system, whose decisions impact on the wellbeing of others on a daily basis. On the other hand, practitioners receive much more education than drivers, and their training is geared towards effective decision-making, which suggests that a focus on regulating via a greater acknowledgement of their internal processes could be effective. That said, in both cases, the vast majority of decisions made are unproblematic.[180] Further, both involve assessments of risk as the key paradigm of regulation,[181] both have death as a possible consequence and, most importantly, both systems of regulation rely on the individual concerned making the decisions themselves — often in time-pressured circumstances. And, of course, deaths happen on the roads regularly as a result of inattention and habitual behaviour.

With respect to the data, in 2019, there were 1,195 road deaths across Australia.[182] While the information on the number of prosecutions that result from the fatalities are not readily available, it is clear that bad decision-making on the road is sanctioned regularly. In the State of Victoria, in a single year, over 2.5 million infringements for traffic infringements were issued.[183] In other words, the ways that the regulatory systems respond to unintended harms are, however, different to that which occurs in the healthcare system. It is likely that, unlike for many medical lapses, a driver deemed to have a role in a crash that caused the death of another road-user would be charged under the relevant legislation.[184]

Taking a step back, there can be seen to be two distinct approaches to attributing liability for harm: the 'person approach and the systems approach'.[185] It appears

180 That is, most treatment decisions do not cause harm, and most decisions made by road users do not cause damage.

181 Of course, money is also a relevant paradigm for road users — either because they are on the road to make money, or because fines act as a negative external motivator. Relationships, too, are important. While there is not often a personal relationship between drivers and their neighbours on the road, those in control of cars need to consider the actions of the road users around them when driving. Knowledge, in the form of experience, also guides decisions around what other road users are likely to do (with such actions linked to, but not dictated by, the road rules).

182 Bureau of Infrastructure, Transport and Regional Economics (Cth), *Road Trauma Australia Statistical Summary* (Statistical Report, 2020) iii <https://www.bitre.gov.au/sites/default/files/documents/road_trauma_australia_2019_statistical_summary.pdf>.

183 Department of Justice and Community Safety (Vic), *Annual Report on the Infringements System 2017–18* (Report, 20 September 2018) 13 <https://files.justice.vic.gov.au/2021-06/Annual%20report%20on%20the%20infringements%20system%202017%2018.pdf>.

184 Such as under the *Criminal Law Consolidation Act 1935* (SA) s 19A. This offence is distinct from that of '[r]eckless and dangerous driving' under the *Road Traffic Act 1961* (SA) s 46.

185 Femi Oyebode, 'Clinical Errors and Medical Negligence' (2013) 22(4) *Medical Principles and Practice* 323, 325. This article cites the Institute of Medicine report that, in turn, cites figures of

that the road safety model is the former, and the regulation of practitioners adopts a more systemic approach.[186] It is acknowledged that a number of practitioners, and institutional limits and pressures, may contribute to a hospital-acquired complication that results in death[187] — so, it is arguable that a single practitioner should not be singled out for prosecution.[188] That said, where there was a dosage error, by a single practitioner,[189] that caused a death, then the whole system may not be liable.[190] It is also true, however, that a number of people, and environmental limits and pressures, may contribute to a mistake on the road[191] — yet the justice system may single out an individual driver. If driver and doctor errors are, instead, considered as decisions made in high mental workload environments, and based in part on unconscious biases or on automatisation, then there is less reason to judge the decisions differently.

The purpose here, though, is not to say that practitioners *should* be regulated more like car drivers; instead the value is to suggest that any assessment that the two forms of regulation *must* be different is ill-informed.[192] Key to both, of course, is

between 44,000 and 98,000 US deaths annually from 'medical errors': Committee on Quality of Health Care in America, Institute of Medicine, *To Err is Human: Building a Safer Health System* (Report, 2000) 1. The report notes that '[e]ven when using the lower estimate, deaths due to medical errors exceed the number attributable to the 8th-leading cause of death. More people die in a given year as a result of medical errors than from motor vehicle accidents [or] breast cancer': at 1, citing Joyce A Martin et al, National Vital Statistics System, *Births and Deaths: Preliminary Data for 1998* (National Vital Statistics Report Vol 47 No 25, 1999) 27–8.

186 Carter notes the role of systemic issues in his analysis of medical manslaughter cases: Carter (n 79) 601–3. Other research has discussed the impact of 'organisational systems', 'workload', 'time pressure', 'teamwork', 'individual human factors', and 'case complexity' on medical errors: Alicia M Zavala et al, 'Decision-Making under Pressure: Medical Errors in Uncertain and Dynamic Environments' (2018) 42(4) *Australian Health Review* 395.

187 It has been noted that 'physician-level factors' in reviews of medical errors have been 'largely ignored': Saposnik et al (n 123) 3.

188 An example such as an error in drug dose, or giving a drug to the wrong patient, is an action that could be attributed to a single practitioner, with 'medication error' being 'widely accepted … [as] the most common and preventable cause of patient injury': Oyebode (n 185) 324.

189 It may be noted, however, that some errors associated with dosages are still the result of systemic issues: see, eg, Johanna I Westbrook et al, 'The Safety of Electronic Prescribing: Manifestations, Mechanisms, and Rates of System-Related Errors Associated with Two Commercial Systems in Hospitals' (2013) 20(6) *Journal of the American Medical Informatics Association* 1159.

190 If the dosage error was the result of exhaustion, then the workplace may attract a degree of responsibility — though if their staff were more regularly prosecuted for errors, then this may lead to institutional-level staffing changes. It would also be possible that a form of conscientious objection could be applied — that is, refusing to work an unsafe number of hours due to the associated risks — though the pro-social motivators of practitioners, coupled with an overconfidence bias with respect to capacities to work while exhausted, means that it is not likely to spread through the profession.

191 For a discussion of the regulatory effect of the road environment, see Chris Dent, 'Taking the Human out of the Regulation of Road Behaviour' (2018) 40(1) *Sydney Law Review* 39. Although the focus of that research was potential issues around the introduction of autonomous vehicles.

192 Some could argue, for example, that doctors are highly educated, that their profession has a high reputation in the community, and so they should be treated differently. This is a somewhat elitist view.

the requirement that practitioners and road users are self-regulating.[193] That is, all doctors and drivers (to take the dominant exemplars) have to make their own decisions on a minute-by-minute basis — otherwise both systems are unworkable. It is the ungovernability of those who make these decisions that renders the health system, and the road transport system, relatively safe. It is the balancing of interests, and the application of knowledge and experience, in an environment built from expertise that does mean most interactions in hospitals, and on the road, are productive.

That said, one difference between the *person* and the *system* approach is in the *visibility* of the sanctions, or the extent to which individuals may remain anonymous after causing a death or serious harm.[194] The relative lack of publicity for medical mistakes that kill may impact on the decisions of practitioners. That is, while it is not clear that all road users have the potential of a criminal prosecution in mind when they are driving, it is less likely that a medical practitioner would have such a thought when considering how they should treat their patients. Further, it is worth noting that sanctions under, for example, the *Road Traffic Act 1974* (WA) are much lower than for manslaughter under the *Criminal Code Compilation Act 1913* (WA)[195] — with respect to imprisonment, it is up to three years for '[c]areless driving causing death, grievous bodily harm or bodily harm' under the former,[196] while it is up to life imprisonment under the latter.[197] In short, while prosecutions for road offences are state-backed, they do not reflect the same level

193 For a discussion of the centrality of self-regulation to road regulation, see Chris Dent, 'Relationships between Laws, Norms and Practices: The Case of Road Behaviour' (2012) 21(3) *Griffith Law Review* 708. That is, proper conduct on the roads is fostered, through public service announcements, by trying to inculcate appropriate norms of behaviour in road users: at 716.

194 One news report refers, anonymously, to a 'doctor [who] may have missed signs of cancer' in 1,500 patients who had undergone endoscopies and colonoscopies. The concerns had been raised in 2018, and AHPRA had imposed restrictions on the doctor's practice in May 2019: Emma Pollard, 'Cancer Signs Potentially Missed in Hundreds of Patients Screened by Surgeon at Redland Hospital, Investigation Launched', *ABC News* (online, 3 January 2020) <https://www.abc.net.au/news/2020-01-03/cancer-signs-potentially-missed-hundreds-of-patients-by-doctor/11839368>. It is not clear that a driver who had made 1,500 mistakes that had potentially harmed the health of others, such that remedial action was being taken, would have been dealt with in the same way. That a leading surgeon is quoted as saying, after a colleague had been suspended after a review of the colleague's actions linked to four patient deaths, '[t]his is the worst day of my professional career. We've lost one of our own': Natasha Robinson, 'The Heart of a Problem', *The Australian* (Sydney, 16 November 2019) 17. This suggests that practitioners may have conflicting motivators when considering their regulation — or, as Robinson asked '[d]o hospitals protect their own over patients?'.

195 It would have been possible for deaths on the road to have stayed a matter for torts and the criminal law; instead, a sui generis system was established. This has become normalised; however, there is value in noting that its introduction was historically contextualised and not a necessary development. For a history of the road rules, see Kieran Tranter, '"The History of the Haste-Wagons": The *Motor Car Act 1909* (Vic), Emergent Technology and the Call for Law' (2005) 29(3) *Melbourne University Law Review* 843.

196 *Road Traffic Act 1974* (WA) s 59BA.

197 *Criminal Code Compilation Act 1913* (WA) s 280.

of *criminality* as offences under the *Criminal Code*.[198] As such, a similar regime could be instituted for deaths resulting from professional actions.[199] Not all medical death prosecutions would be publicised, in the same way that not all careless driving prosecutions achieve notoriety — any, however, may impact on the attention paid by practitioners. All that is being suggested here is that the negative motivator (both in terms of punishment and reputation) could have a greater role — if the public *shaming* of drivers who make mistakes is seen to be effective from a regulatory perspective.[200] The effectiveness of such a change, however, would need to be explored through future research.

D *Ungovernable Patients, or Decisions Made in Relationships?*

Finally, there can be recourse to the relational context of medical decisions. If it is accepted that practitioners are ungovernable, in Black's sense of the word, then there is value in acknowledging that patients are too. That is, all patients' actions are guided by motivators and are the result of conscious and/or unconscious pressures and decisions. Key decisions of patients include (1) at what stage of their symptoms or condition do they see a practitioner;[201] (2) how much information do they provide the practitioner;[202] and (3) even what type of practitioner the patient chooses to see.[203] And, of course, there may be issues with the extent to which a

198 Expressed differently, a new system could sidestep the issues of the current framework. That is, while 'doctors may well be negligent in their treatment of patients, the degree of negligence required for a manslaughter conviction is high and may not be provable on the facts': Dobinson (n 179) 112. A new offence of carelessness could have a different standard.

199 Given the argument here, it would include healthcare professionals. It could also include other occupations, such as police officers. There are conceptual links with industrial manslaughter frameworks, but there is not the room to explore those connections more completely.

200 Though it has also been suggested that '[f]or most errors, though, the criminal law is unsatisfactory. Convicting doctors of manslaughter may satisfy a desire for retribution, but deters careful consideration of the ways of preventing tragedies from recurring': R E Ferner, 'Medication Errors That Have Led to Manslaughter Charges' (2000) 321(7270) *British Medical Journal* 1212, 1216. To establish the validity of such an assessment would take sufficient research, particularly across a range of professions.

201 This circumstance has been the subject of legal dispute. A patient who failed to contact a specialist for a condition she knew was dangerous was held to be 20% liable for the harm she suffered: *Kalokerinos v Burnett* (New South Wales Court of Appeal, Kirby P, Clarke and Powell JJA, 30 January 1996).

202 This circumstance has also been the subject of legal dispute. A patient was assessed to be liable for contributory negligence on the grounds that her 'bowel troubles … were much more frequent and indeed [more] serious than she disclosed to [her doctor]': *Locher v Turner* (Queensland Court of Appeal, Pincus JA and Byrne J, 21 April 1995) 15.

203 Most individuals in Australia would not consider seeing a Traditional Chinese medicine ('TCM') practitioner and many would not see a chiropractor — on the basis that the potential patients do not think that the knowledge of these practitioners is as effective as *Western* medicine practitioners. A recent study has indicated that only 12.6% of the Australian population sees a chiropractor and 5.3% see a TCM practitioner: Steel et al, 'Complementary Medicine Use in the Australian Population: Results of a Nationally-Representative Cross-Sectional Survey' (2018) 8 *Scientific Reports* 17325:1–7, 5. Both professions are, however, also regulated by AHPRA and, therefore, are seen to operate in light of a defined body of knowledge.

patient can understand the information provided by their practitioner[204] — impacting on their capacity to make a *good* decision.

The decisions of ungovernable patients are also relevant to the treatment decisions of practitioners.[205] Given the importance of the relationship-based nature of treatment, a practitioner may modify treatment decisions in order to facilitate the patient to see them again in future.[206] Recent research has suggested that a significant number of doctors prescribe active placebos.[207] These are active compounds, as opposed to the classic sugar pills,[208] that, however, are not usually prescribed for the symptoms exhibited by the patient — such as prescribing antibiotics for a viral presentation. The main reason given for the prescription was 'to enhance positive expectations'.[209] In other words, despite the doctor having the knowledge of the ineffectiveness of the treatment, they are choosing not to educate the patient[210] — potentially because they do not think that the patient, given their preconceptions and biases, would accept the doctor's reasoning.[211] Valid health

204 'With the exception of a few limited studies of comprehension, studies of patients' decision-making typically pay little attention to information processing. Too much information can be as much of a problem as too little. Information overload may prevent adequate understanding, and this problem is exacerbated if unfamiliar terms are used': Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 5th ed, 2001) 90.

205 The preferences of patients also may impact on what a practitioner does — the distinction between 'informed consent' and 'consent' is that the latter only requires the practitioner provide sufficient information to the patient such that they understand the procedure, or consequences, in broad terms: *Rosenberg v Percival* (2001) 205 CLR 434, 440 (Gleeson J), quoting *Rogers* (n 118) 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). This means that, if a patient is unduly anxious, then the practitioner does not have to provide the level of information such that they would be fully informed, if the additional information would unnecessarily contribute to their anxiety.

206 More specifically, research in the UK has shown that GPs have changed behaviour in order 'to reduce the possibility of a patient complaining': Towse and Danzon (n 171) 97, citing Nicholas Summerton, 'Positive and Negative Factors in Defensive Medicine: A Questionnaire Study of General Practitioners' (1995) 310(6971) *British Medical Journal* 27, 29. This is a practice that can be seen in terms of the practitioner wishing to maintain the relationship.

207 77% of surveyed doctors reported prescribing active placebos: Kate Faasse and Ben Colagiuri, 'Placebos in Australian General Practice: A National Survey of Physician Use, Beliefs and Attitudes' (2019) 48(12) *Australian Journal of General Practice* 876, 878. On the other hand, only 39% of doctors reported prescribing inert placebos: at 879.

208 Sugar pills are inert placebos as they have minimal effect on the body of the patient but may impact on their mind: ibid 876–7.

209 Faasse and Colagiuri (n 207) 879. Another study highlighted that 'loss of reputation' and 'peer pressure' were factors in practitioners inappropriately prescribing antibiotics: Alex Broom et al, 'Myth, Manners, and Medical Ritual: Defensive Medicine and the Fetish of Antibiotics' (2017) 27(13) *Qualitative Health Research* 1994, 2003.

210 The 'overuse of antibiotics is not a knowledge or diagnostic problem, it is a psychological one' (a statement made in the context of a discussion of cognitive biases in health decisions): Scott et al (n 123) 4, citing Ateev Mehrotra and Jeffrey A Linder, 'Tipping the Balance Toward Fewer Antibiotics' (2016) 176(11) *Journal of the American Medical Association: Internal Medicine* 1649, 1649.

211 With the patient, as a result, moving to a practice that would prescribe what the patient was after.

policy concerns with respect to antibiotic resistant bacteria[212] are, therefore, put aside by doctors for shorter term interests.[213]

The ungovernability of patients is most evident in the more extreme case of *anti-vaxxers*.[214] While some allied health practitioners do affirm anti-vax beliefs,[215] the point here is to highlight that a number of patients will espouse ideas that are contrary to accepted medical knowledge.[216] Practitioners will still have to engage with them regardless and practitioners may also be seen to have a role in putting effect to government policy.[217] This means that the beliefs of the patients, which may be very difficult to change, may impact on the decisions of the practitioners — including the decision to refuse medical care.[218] Practitioners, of course, may, when restricting treatment, be motivated to protect the health of other patients (such as those too young to be vaccinated), or the reputational effects of having

212 The World Health Organization has said that '[a]ntibiotic resistance is one of the biggest threats to global health, food security, and development today': 'Antibiotic Resistance', *World Health Organization* (Fact Sheet, 31 July 2020) <https://www.who.int/news-room/fact-sheets/detail/antibiotic-resistance>. This point was reinforced — 'antibiotic resistance is a major threat to human health' — by the Australian government on a website aimed at the general community: 'Antibiotic Resistance', *healthdirect* (Web Page, May 2020) <https://www.healthdirect.gov.au/antibiotic-resistance>.

213 These interests may be based on the assumption, or biases, that the health of the patient is best served by staying with the doctor — regardless of any evidence as to whether it is, or is not, the case.

214 The literature considers the issue in terms of 'vaccine hesitancy' — as a result of the power of words: Matthew Z Dudley et al, 'Words Matter: Vaccine Hesitancy, Vaccine Demand, Vaccine Confidence, Herd Immunity and Mandatory Vaccination' (2020) 38(4) *Vaccine* 709.

215 The Chiropractic Board of Australia has, in its 'Statement on advertising', the requirement that '[c]hiropractors should not display, promote or provide materials, information or advice that is anti-vaccination in nature and should not make public comment discouraging vaccination': Chiropractic Board of Australia, 'Statement on Advertising' (Media Release, 7 March 2016) <https://www.chiropracticboard.gov.au/News/2016-03-07-statement-on-advertising.aspx>. Not all national boards include reference to anti-vaccination material.

216 For a discussion of this belief in terms of unconscious biases, see Matthew Motta, Timothy Callaghan and Steven Sylvester, 'Knowing Less but Presuming More: Dunning-Kruger Effects and the Endorsement of Anti-Vaccine Policy Attitudes' (2018) 211 (August) *Social Science and Medicine* 274.

217 It may be pointed out that a range of factors contribute to lower than optimal vaccination rates — including limited access to health services, low social support and competing pressures (such as time pressures resulting from having a large family): Anna Pearce et al, 'Barriers to Childhood Immunisation: Findings from the Longitudinal Study of Australian Children' (2015) 33(29) *Vaccine* 3377, 3380. On the other hand, the 'proportion of the overall population strongly opposed to vaccination is small, with little evidence that it is increasing': Frank H Beard, Julie Leask and Peter B McIntyre, 'No Jab, No Pay and Vaccine Refusal in Australia: The Jury is Out' (2017) 206(9) *Medical Journal of Australia* 381, 382. These findings are, obviously, from before the Covid-19 pandemic. For a more recent review of fifteen studies of hesitancy towards Covid-19 vaccination that reflect a higher level of resistance, see G Troiano and A Nardi, 'Vaccine Hesitancy in the Era of COVID-19' (2021) 194 (May) *Public Health* 245.

218 One survey found that 17% of children who were not fully up-to-date with vaccinations had been 'refused care by a health care provider': Anthea Rhodes, The Royal Children's Hospital Melbourne, *Vaccination: Perspectives of Australian Parents* (Poll No 6, March 2017) 5 <https://www.rchpoll.org.au/wp-content/uploads/2015/10/ACHP-Poll6_Detailed-report_FINAL.pdf>.

anti-vax patients.[219] The parents, in turn, are motivated by the desire to protect their children from the, in their minds extreme, potential side effects of the vaccine.

From a regulatory perspective, the comparison of the active placebos and anti-vaccination issues shows a difference in behaviour on the part of the practitioners. In both cases, the patients, or their parents, espouse views that are counter to the findings of medical science. In both cases, significant public health concerns are at stake.[220] In one, however, the practitioners choose to prioritise patients' expectations/demands and in the other, the practitioners resist, to the extent of refusing treatment. The difference in approach may be the result of unconscious biases.[221] As a result, merely asserting, or assuming, that practitioners accept, and act in accordance with, medical science (or the knowledge of their profession) does not allow for the fact that engaging with the beliefs of their patients also impacts on specific decisions of the practitioners.

VI CONCLUSION

There are no solutions, here, to the better decision-making of healthcare practitioners. Mechanisms for the promotion of better decisions already in place include the need for continuing education and the provisions for training.[222] Even the paradigm of money, in the context of the health system, can be seen to prioritise good decisions — a sole practitioner will get more patients (and earn more) if they make better treatment decisions (of course, the risks of over-servicing, or short consultation times, as noted above, means that money cannot be seen as only promoting good decisions). It is not clear, however, how the system does, or indeed can, reduce the role of potentially problematic biases and heuristics — the unacknowledged aspects of decisions.

Instead, this analysis shows that a broader understanding of the regulation of healthcare practitioners allows a consideration of the decision-making of those practitioners — including the multiple pressures that impact on all their actions. In other words, there is value in seeing the inculcation of good decisions in terms of the more effective establishment of norms, rather than any focus on retrospective regulation. This, in turn, allows a greater acknowledgement that the motivations of practitioners vary and that their treatment decisions may be subject to unconscious

219 It is possible, for example, that anti-vaxxers may share, via social media, the names of doctors who are less critical of their perspective. In many practices, however, there may be no reputational impact of having anti-vax patients.

220 Though there is a very low risk of any individual prescription of antibiotics increasing antibiotic resistance in bacteria; but then, there is also only a very low risk of one individual resisting vaccination leading to an increase in the spread of the target disease.

221 It could reflect an unconscious acceptance of the understandable or reasonable request for antibiotics versus a rejection of the *unreasonable* rejection of vaccinations. It is also possible that a bias could be the result of individual doctors having treated patients with measles (and others that can have their incidence reduced through vaccines) but not having treated patients with antibiotic resistant infections.

222 Including the student registration provisions in pt 7 div 7 of the *National Law* (n 57). That said, the literature on decision-making does offer some insights into how behaviours may be improved: see, eg, Reiter-Palmon et al (n 114). It also provides insight into the 'nudges' highlighted in Wang and Groene (n 4) 3.

biases and heuristics. As such, it is an approach that is distinct from one that focuses on responses to bad behaviour. More broadly, the value of this discussion of the regulation of decisions is based on the assessment that multiple legal regimes aim to control actions in the area, doctors engage with the law in a range of ways, and that patients are active participants in the process.